U.S. Department of Labor

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Issue date:

04Dec2001

In the Matter of:

CASE NO. 2001-LHC-0394
OWCP NO. 18-72636

MARIA CARDENAZ,
Claimant,
vs.

MAERSK PACIFIC, LTD.,
Employer,
and

COMMERCIAL INSURANCE SERVICES.,
Carrier.

Appearances:

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One World Trade Center, #1840
Long Beach, CA 90831
For Maersk Pacific, Ltd.

Richard E. Schwartz, Esq.
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For Claimant Maria Cardenaz

Before: Anne Beytin Torkington
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS IN PART AND DENYING THEM IN PART

This case involves a claim arising under the Longshore and Harbor Workers' Compensation Act, as amended (hereinafter "the Act" or "the Longshore Act"), 33 U.S.C. § 901 *et seq.* A formal hearing was held in Long Beach, California, on July 25 to July 27, 2001, in which both parties were represented by counsel and the following exhibits were admitted into evidence: Administrative Law Judge's Exhibits 1 and 2 ("ALJX-1" and "ALJX-2")[1], Claimant's Exhibits ("CX") 1,2, 4-6, 8-12, 14-57, 60, 62-65, 68, 70-73; and Employer's Exhibits ("EX") 1 through 27. Tr.54-56.

Stipulations: The parties agreed to the following stipulations:

1. The parties are subject to the Act;

2. Claimant and Employer were in an employer-employee relationship at the time the alleged injury occurred;

3. The alleged injuries to Claimant's head, neck, chest, left shoulder, and contusions to left knee occurred on February 8, 2000;[2]

4. Claimant also claims injuries to her psyche, back, right knee, and right shoulder, which are disputed by Employer;

5. The injuries enumerated in stipulation #3 arose out of and in the course of employment;

6. Employer had timely notice of the alleged injuries;

7. Claimant filed a timely claim for compensation;

8. Claimant's average weekly wage at the time of injury was $1,644.33, giving her a compensation rate of $901.28 per week;

9. Claimant has not returned to her former job;

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[1] Administrative Law Judge's Exhibits were Claimant's Pre-Trial Statement ("ALJX-1"), and Employer's Pre-Trial Statement ("ALJX-2"). See Transcript, ("Tr.") at 15.

[2] After a full review of the evidence, the undersigned finds that this stipulation applies to soft-tissue injuries only, all of which Employer alleges were healed by March 25, 2000. Employer's experts all testified that Claimant suffered soft tissue injury on the night of February 8, 2000.

10. Employer voluntarily paid compensation for temporary total disability from February 9, 2000, to June 7, 2000, and reinstated such compensation at the recommendation of the Administrative Law Judge from February 15, 2001, to the present;[3]

11. The total sum paid between February 9, 2000, and June 7, 2000, was $15,450.67, and between February 15, 2001, to July 18, 2001 was $19,828.16.

The Court accepts all of the foregoing stipulations as they are supported by substantial evidence of record. See *Phelps v. Newport News Shipbuilding & Dry Dock Co.*, 16 BRBS 325, 327 (1984); *Huneycutt v. Newport News Shipbuilding & Dry Dock Co.*, 17 BRBS 142, 144 fn. 2 (1985).

Issues in Dispute:

1. Did the claimant's injury to her back, right knee, right shoulder, and psyche arise out of and in the course of employment as a result of the accident which occurred on February 8, 2000?

2. What is the extent of Claimant's temporary total disability from all injuries found to be the result of the industrial accident at issue?

3. Is Claimant entitled to §7 benefits for
   (a) surgery to her cervical spine and right knee;
   (b) psychiatric treatment;
   (c) self-procured medical treatment from
      i) Dr. Halote under §7(d)(1);
      ii) diagnostic studies ordered by Dr. Nagelberg;
      iii) treatment from Dr. Freed?

SUMMARY OF DECISION

Claimant's injuries to her back, right knee, right shoulder and psyche, beyond any soft tissue injury, did not arise out of and in the course of employment as a result of the accident which occurred on February 8, 2000. Thus, the issue of the extent of Claimant's temporary total disability in regards to these disputed injuries is moot. Regarding Claimant's soft tissue injuries to her head, neck, chest, left shoulder and contusions to the left knee, Claimant reached maximum medical improvement as of March 25, 2000. She was able to return to her full-time position as a longshore worker as of that date, without restriction. Claimant is not entitled to section 7 benefits for surgery to her cervical spine, nor her right knee, nor any medical treatment procured from Dr. Nagelberg after June 7, 2000

[3]"Present" means the date the trial commenced, July 25, 2001. The Court recommended that compensation cease in its Preliminary Order issued August 2, 2001.

except for his referral to Dr. Freed on July 13, 2000. Further, she is not entitled to benefits for psychiatric treatment procured from Dr. Halote. Finally, Claimant is entitled to section 7 benefits for her examination by Dr. Freed.

SUMMARY OF EVIDENCE

Claimant's Testimony and Background

The undisputed facts are as follows:

Claimant, Maria Cardenaz ("Claimant") was born on July 1, 1952, and at the time of this hearing was 49 years of age. CX-16, p. 258. She is divorced and has two adult daughters, one teenage son, and a 10 year old granddaughter. Tr.952-954. Claimant completed 7 years of school in Mexico. Tr.947. She attended 4 months of high school in the United States, but did not graduate. CX-16, p.259. In 1995, Claimant began working as a casual for Pacific Maritime Association until she became a Class B longshoreman sometime around 1998. Tr.578-579. Claimant obtained Class A status on June 4, 2001. Tr.1137. Claimant worked primarily as a UTR operator,[4] but has done other jobs including lasher, forklift operator, gearperson, groundperson, signalperson, pin person, hatch clerk, gate clerk, and key clerk. CX-16, p.280-281, Tr.1138, 1147, 1149, 1152. Claimant testified she "was doing everything." Tr.592. In February, 1990, while working for Santa Fe Railroad, Claimant had her first industrial accident, in which she sustained an injury to her back and her left knee, causing her to be placed on temporary total disability. Claimant had left knee surgery, and in October, 1991, she returned to work without restriction. Tr.570-576.

On the night of February 7-8, 2000, Claimant was working as a UTR operator when a container shifted or fell on the fifth wheel of her truck, causing it to bounce up and down approximately three times. Claimant was inside the cab of the UTR without a seatbelt. She was thrown about the cab, sustaining injuries to her left neck, left chest, and a cut on her left knee. EX-6, p.14. Claimant was taken by ambulance to St. Mary's Hospital, where she was examined by Dr. Steven Shea. X-rays were taken, and the cut on her left knee was closed with surgical staples. Claimant was diagnosed with multiple contusions and released home. EX-6, p.14.

The exact details of how the accident occurred are not clear, but neither are they crucial to the issues in dispute. Claimant did testify to her version of the events of that night, stating that she was bounced up and down inside the cab three times. At first Claimant testified regarding the events that occurred in the truck, "then I don't know how it happened, it was so fast." Tr.724. She then testified to the degree of the angles her UTR reached when it bounced each time. Tr. 729, 740, 746. In response to a series of leading questions on direct examination, Claimant testified to the details of the accident, including how she was standing during each bounce, what part of her body was struck by which part of the interior of the UTR on each bounce, as well as where her hands and feet were

[4]The job entails driving a semi-truck, picking up cargo containers and moving them into position to be loaded on to the ship. Tr.703, 714.

at any given moment. Tr.731, 734-736, 745. Following testimony of defense medical experts that twisting and weight bearing would lead to a meniscal tear,[5] Claimant, through leading questions by her attorney, testified to the mechanism of her alleged right knee injury as a twisting, weight-bearing injury. Tr.731, 734-737, 739.

However, on cross-examination, Claimant admitted that the accident happened "very fast". Tr.1174. Claimant testified on direct that she "doesn't know how or what happened." She was looking at the top-handler,[6] Mr. Villanueva, watching him, looking back at him. Tr.720. She further testified that she was able to see the container in the mirror while Mr. Villanueva was lifting it. Tr.730. On cross-examination, she didn't remember whether she was looking in the rear-view mirror, or watching directly when the accident occurred. Tr.1174. Yet she testified that she was sure that she was in a better position than Mr. Villanueva to see the accident occur, even though she stated he was up in the cab of the top-handler and "the upper cab is high enough for him to see everything." Tr.1177. On direct examination, Claimant stated that she saw Mr. Villanueva raise the container approximately five or six feet in the air, Tr.722-723, then on cross-examination she began at 5-7 feet, then increased her estimate to as much as 12 feet in the air before it fell on her fifth wheel. Tr.1175-1176. Claimant's version of the accident is not credible, nor was her other testimony.

For the following reasons, I do not find Claimant to be a credible witness:

Claimant first testified that she did not mention any injury to her right knee immediately following the accident, or later that day at Kaiser. She stated she did not notice the injury until she tried to walk without crutches, three or four days after the accident. Tr. 1018-1019. Claimant then changed her testimony, asserting that she told the nurse at St. Mary's, immediately following the accident that she hurt her right knee, but the nurse did not write it down. Tr. 1019-1020.

Claimant testified on direct examination that she went to Kaiser Permanente on February 10, 2000. Tr.877. She testified that the doctor there looked at her breast, told her she had a critical condition and needed to go to the emergency room. He could not help her in the clinic. Claimant testified she chose not to go to emergency, and instead returned home. Tr.878-879. According to the hospital records however, the visit to Kaiser occurred on the afternoon of February 8, 2000. The nurse who examined Claimant classified her as a non-urgent patient. CX-10, p. 19. The screening assessment was "Clinical presentation is not consistent with an Emergency Medical Condition at this time per Standardized Procedure." CX-10, p. 19. On cross-examination, Claimant stated she had no memory of going to Kaiser on February 8, it was two or three days later. Tr.1017.

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[5]See, Dr. London's testimony of the mechanism of a meniscal tear injury, Tr.452-454 and Tr.605-608; Dr. Nagelberg's testimony, Tr.316-317; Dr. Rothman's testimony, Tr.377-378; as well as a hypothetical question posed by counsel for Claimant to Dr. London, Tr.483-484.

[6]The top handler lifts the containers when a driver needs help maneuvering the truck underneath it. Tr.709. He would have been positioned beside the container and chassis at the time of the accident. Tr.718.

On February 10, 2000, Claimant was sent to see Dr. John Burns at Priority One, in Long Beach, by Mr. Ray Courtois, the insurance adjuster. Tr.881. At this point, Claimant complained of injury to her left knee, neck, back, left side of her body, and her right shoulder. Although it is not included in Dr. Burns' report, Claimant insists she told Dr. Burns she was experiencing pain in her right knee as well, and that Dr. Burns refused to examine her right knee without authorization from Mr. Courtois. Tr.1011. Dr. Burns diagnosed contusions/bruising to left knee, neck, breast, laceration left knee, and prescribed ice, moist heat, 500 mg. naprosyn, and vicodin. EX-7, p.15. Claimant also testified that she is certain she complained of right knee pain on subsequent visits, but again, there is no notation in any of Dr. Burns' reports to that effect. Tr.1013-1015. See EX-7, pp. 15, 18-20. Claimant testified that Dr. Burns did nothing for her, the only treatment he gave her was "killer pills for pain." Tr.882.

Claimant then remembers that she underwent physical therapy at the recommendation of Dr. Burns. Tr. 887. After seven sessions, she was referred to Dr. Sarbpaul Bhalla, an Orthopaedist, as Claimant testified, because Dr. Burns wanted "to know why do you still feeling those pains, weird pains." Tr.883.

Claimant then changed doctors. She saw Dr. Nagelberg on March 28, 2001, four days after her appointment with Dr. Bhalla. At this point, her symptoms had expanded to include her entire back, numbness and tingling in her arms and hands, pain radiating into her legs, and numbness and tingling in her legs. EX-18, p.478-479.

Claimant gave conflicting testimony on several occasions:

When asked on cross-examination how her back was feeling sitting in court on July 27, 2001, Claimant testified that her back was not bothering her "right now." Tr.1148. When asked again a short time later if she was experiencing back pain that day, Claimant testified "Yes," and gave the pain a rating of seven on a scale of one to ten, ten being the most severe pain. Tr.1161.

Claimant's testimony regarding the effectiveness of the physical therapy prescribed by Dr. Nagelberg changed continually. On direct examination, she testified that the therapy was helping "a little bit," "the pain would go away for a little bit, for one day, but come back." Tr.916. She then testified that she told Dr. Nagelberg in September, "that it doesn't work". Tr.918. At this point, Dr. Nagelberg instructed Claimant to stop going. She continued to go for another four months, regardless of her feeling that it was not working. Tr.919. Claimant then testified that in January she stopped going because she just didn't want to go anymore. Tr.919. Yet during cross-examination, Claimant testified that in January, while being video taped by an investigator, she had "just a little pain, [that day,] because the therapy help [sic] me." Tr.1117. And again, Claimant testified on cross-examination that her condition was improving with all that physical therapy, and has worsened since she stopped going. Tr.1166.

Claimant asserts that she has difficulty understanding English. She testified at her deposition through an interpreter. She asserted that she could not understand the questions without one. EX-16, p.263. Yet she further testified that she converses with people in both English and Spanish. EX-

16, p.264. At trial, on occasion, when asked if she needed the aid of the interpreter, Claimant stated she did not, and answered the question in English.[7] Tr.720, 1208. Claimant testified that she sometimes reads the Los Angeles Times in English, but then clarified by saying she does not understand what she is reading. EX-16, p.265. She testified that all of her doctors' appointments were conducted in English, without any difficulty understanding their questions. EX-16, p. 266-274. At trial, the majority of Claimant's testimony was taken without the aid of an interpreter. Albeit there was the occasional misunderstanding, overall, I do not believe that Claimant has a problem understanding or communicating in English.

Claimant was confronted with her own image on video tape, 'gesturing' to a private investigator.[8] Claimant testified she had no recollection of waving to him, or of making obscene gestures. Tr.1102-1103. Claimant asserted she had never seen the two gentlemen who had just testified they had been following her. She was actually being followed by an old man. Tr.1107-1108. In addition to her 'gesturing,' the video shows Claimant entering her vehicle, reaching back over her shoulder for her seatbelt, turning her neck to back out of a parking lot, and driving away. Claimant was also taped sitting in her vehicle, and bending forward. See, EX-25. While she had no recollection of ever gesturing or being video taped, she could clearly remember that on the day in question, she was "feeling better because [she] had therapy, and that helped [her] to unloose [her] muscles and do something." Tr.1116.

Claimant testified that she cannot work in any capacity as a longshore worker in her present condition. Tr.1148.

Medical Evidence

Dr. John Burns:

Dr. John Burns examined Claimant on February 10, 15, 18 and 22, 2000 as well as March 20, 2000, for a total of five visits. During the first examination on February 10, Claimant presented with complaints of left knee, left breast, and neck pain. Dr. Burns noted objective findings of tenderness and 50% decrease in range of motion in Claimant's left neck. Her left breast was laterally swollen, tender and ecchymosic. Claimant's left knee was swollen, and had a staple in place. Dr. Burns noted Claimant favored her left foot. Claimant's range of motion was 16 degree extension, and she could flex to 90 degrees. Claimant's left knee laceration was clean and dry. Dr. Burns diagnosed contusions and bruising to the left knee, neck, breast, and a laceration to the left knee. He prescribed 500 mg. Naprosyn, Vicodin, ice and moist heat. Dr. Burns ordered Claimant off work, and re-

[7]The undersigned asked, while describing the accident, if a term was too technical, and if Claimant needed an interpreter. She responded, "No, no. The broomer (phonetic) is the part of the machine that runs the containers. That's the name for the part, broomer." Tr.720. Claimant understood and gave a definition of "hallucinating." Tr.1208.

[8]See Mr. Winstanley's testimony, at p. 46, *infra*.

scheduled an appointment for February 15, 2000. EX-7, p.15.

Dr. Burns saw Claimant three more times, giving the same diagnosis on each occasion. He maintained Claimant's status as temporarily totally disabled. EX-7, p.16-20. On March 20, 2000, Dr. Burns examined Claimant and referred her to an orthopedic surgeon for further evaluation.[9] He declared Claimant temporarily totally disabled "as per ortho." CX-12, p.23.

Dr. Sarbpaul Bhalla:

Dr. John Burns, Claimant's treating doctor, referred Claimant to Dr. Bhalla. Dr. Sarbpaul Bhalla examined Claimant on March 24, 2000. Dr. Bhalla is a board certified orthopedic surgeon. On this occasion, Claimant complained of pain in the left hand and neck, left knee, right knee, low back. She denied any pain radiating toward her upper or lower extremities, and no numbness or radicular symptoms. EX-8, p.22. Dr. Bhalla examined Claimant, finding that she walked with a normal heel/toe gait, and was not in any acute distress. Her cervical spine was in the center when examined in a sitting position, and she had complete range of motion. She could touch her chin to her chest, her extension was 35 degrees, side bending 30 to 35 degrees, and rotation was 90 degrees on either side. Cervical compression test was negative. Distraction test was also negative. EX-8, p.23.

Upon examination of the upper extremities, Dr. Bhalla found Claimant to be completely normal. There was no evidence of ecchymosis in the left hand, no thenar or hyperthenar wasting. Tinel's sign was negative, as was phalen's test. Claimant had normal and equal strength on both sides. EX-8, p.23.

The examination of the lower extremities revealed that Claimant had a scar on her left knee that was well-healed, with no effusion. She had complete, and pain free range of motion with no joint line tenderness. The examination of Claimant's right knee was negative: no effusion, complete range of motion from 0 to 135 degrees, no ligamentous or bony tenderness and no meniscal sign. The lower back examination showed no evidence of any abnormal spasm nor any abnormal lumbar lordosis. The straight leg raising test was bilaterally normal. The neurological examination was completely normal. EX-8, p.23.

Dr. Bhalla's assessment and recommendation was as follows:

> The orthopedic examination is completely normal, rather the patient has an abnormal exaggerated response to even the slightest touch to the skin. The patient complains of out of proportion discomfort, which does not go with organic pathology. I feel this patient should go back to work without restrictions and does not need any treatment. EX–8, p.24.

Dr. Bhalla released Claimant from temporary total disability status, and sent her back to work

[9]The report dated March 20, 2000, is difficult to read. Dr. Burns' handwriting is illegible in places, especially his diagnosis, and the undersigned has done her best to decipher it.

on March 25, 2000, without restriction. EX-8, p. 25.

Dr. Steven Nagelberg:

Dr. Steven Nagelberg testified for Claimant, as an expert, specializing in the area of orthopedic surgery. Tr.220. See Curriculum Vitae of Dr. Nagelberg, CX-36, p. 70-79. Dr. Nagelberg has been a board-certified orthopedic surgeon since 1987. CX-36, p.70. Dr. Nagelberg began treating Claimant on March 28, 2000, and continued to see her regularly up until the time of trial. Tr.221.

In his report dated March 29, 2000, Dr. Nagelberg lists Claimant's current complaints as: recurrent headaches, nausea, and dizziness, pain in the left cheek, pain to the touch; continuous neck pain, radiating into her shoulder and entire back; numbness and tingling in arms and hands, left more than right; continuous pain in lower, mid, and upper back, radiating to her legs, numbness and tingling in legs, weakness, pain increasing with prolonged standing; continuous pain in right leg, extending to her foot, buckling and giving way of her right knee, as well as swelling, popping and clicking; recurrent pain in her left breast, chest, and ribs, as well as soreness in her left buttock. CX-24, p.37-38, Tr.242-243. Dr. Nagelberg took a history of the accident which described the mechanism of injury as one occurring while Claimant was driving a forklift. Claimant was thrown back and forth when a box fell onto the forks of the forklift, causing it to bounce three times. CX-24, p.35. On cross-examination, Dr. Nagelberg testified he did not review any medical reports of treatment Claimant received following the accident. Tr.243-274.

Upon examination, Dr. Nagelberg found that Claimant suffered from moderate posterior cervical and bilateral trapezial tenderness, as well as tenderness of the dorsal paravertebral musculature. Claimant's range of motion of the cervical spine was limited, lacking 50 percent of motion in all planes. A neurological examination of the upper extremities showed "motor examination" intact in all muscle groups tested, sensation intact to pinprick and light touch, Claimant's reflexes were 2+ bilaterally, and no pathological reflexes were noted. CX-24, p.38.

Dr. Nagelberg's examination of the lumbar spine revealed that Claimant suffered from moderate posterior tenderness. She could flex to 45 degrees and extend to 5 degrees. A neurological examination showed "motor examination" intact in all muscle groups, and sensation was intact to pinprick and light touch. Claimant's reflexes were 2+ bilaterally, and a straight leg raising test was negative bilaterally at 90 degrees for radicular pain. CX-24, p.39.

Dr. Nagelberg examined Claimant's left knee, finding multiple well-healed scars.[10] He noted pain with patella compression bilaterally, more on the left than right. There was subpatella crepitus

[10]Dr. Nagelberg testified on cross-examination that although the heading to this section of his report was "Left Knee", he did, in fact examine both knees. He stated that while the report is written in the singular, "knee", he was speaking of both the left and right knee at the time. Tr.282-283.

bilaterally, more on the left than right. Range of motion of Claimant's knee was full, there was no significant medial or lateral instability and a negative anterior and posterior drawer sign.[11] CX-24, p.39.

Dr. Nagelberg obtained x-rays of Claimant's cervical and lumbar spine, finding no significant abnormalities in either. Dr. Nagelberg's impressions were: 1. Cervical radiculopathy; 2. Lumbar radiculopathy; 3. Internal derangement, left and right knees. Dr. Nagelberg referred Claimant for physical therapy, consisting of acupuncture and chiropractic treatment three times a week for six weeks, prescribed Ultram[12] for pain, and stated an MRI of both the cervical and lumbar spine, as well as the left knee would be obtained. He also requested authorization for a TENS unit. CX-24, p.40. Dr. Nagelberg declared Claimant temporarily totally disabled for six weeks. CX-14, p.25.

Dr. Nagelberg arranged for Claimant to undergo nerve conduction studies with Dr. Patricia Meredith on September 19, 2000. EX-13, p.130-143. These tests were ordered to help quantify and determine the source of Claimant's upper and lower extremity complaints. The results of these tests were normal. Dr. Nagelberg testified on cross-examination that "there's no electric diagnostic evidence of radiculopathy in the upper extremities." Tr.250. Dr. Nagelberg testified the significance was that not all of her pain can be explained by an orthopedic abnormality. To him this meant "that she may benefit from surgery, but may not completely benefit from surgery." Tr.246.

In July, August and September of 2000, Dr. Nagelberg sent Claimant to undergo epidural steroid injections to provide her with some temporary or lasting relief of pain. Tr.247. These injections resulted in temporary relief, "but nothing of any lasting fashion." Tr.248. Similarly, the physical therapy, acupuncture and chiropractic treatments Claimant underwent were of no lasting benefit. Tr.249. Dr. Nagelberg testified he instructed Claimant to stop attending physical therapy on August 29, 2000. Tr.295-296. Records indicated that Claimant continued to go 3-4 times a week, until January 29, 2001. CX-68, p.570-579. Dr. Nagelberg stated "that was inappropriate." Tr.296.

Dr. Nagelberg testified that, under his care, Claimant underwent an MRI of the thoracic spine, which was normal, and an MRI of the lumbar spine, also normal. Tr.233. In a supplemental report dated July 27, 2000, Dr. Nagelberg reported his findings after reviewing the MRI of the lumbar spine. His report states: "I am hopeful that the patient will respond to nonoperative care. If she does not, additional diagnostic testing, including lumbar discography for a definitive diagnosis of the disc abnormality at the L5-S1 level, would be indicated." CX-27, p.48. On cross-examination, Dr.

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[11]Here, Dr. Nagelberg testified that this statement referred to both knees. Although the report did not state "bilaterally," Dr. Nagelberg testified "I'm telling you it's bilaterally, because I examined both knees, because the information that's present is commingled involving both knees." Tr.284.

[12]A centrally acting non-narcotic pain-reliever prescribed for mild to moderate pain relief. *The Pill Book*, 7th ed., 1996, p.1124-1125.

Nagelberg explained the report indicates that Claimant had a minor degree of disc degeneration at L-4/S-1 [sic]. He was merely considering discography, if Claimant's pain became unbearable. He testified "I'm not recommending discography for her. At this point at least." He further opined Claimant is not a candidate for lower back surgery.[13] Tr.291.

An MRI of the left knee was done on May 13, 2000. No abnormalities were noted in that study, and Dr. Nagelberg testified that Claimant did not require left knee surgery. Tr.289. Dr. Nagelberg was cross-examined on a report dated July 13, 2000, in which he stated "it is becoming increasingly likely the patient will ultimately require surgery, including anterior cervical discectomy and fusion, as well as left knee arthroscopy." Dr. Nagelberg testified that he was simply indicating his thoughts at that point, based on Claimant's complaints of a lot of pain in her left knee. He asserted he never formally recommended it, and Claimant does not require left knee surgery.[14] Tr.289. In a subsequent report dated December 13, 2000, Dr. Nagelberg noted "she may require diagnostic left knee arthroscopy." Dr. Nagelberg testified that again, this is simply an indication that she *may* need left knee surgery, but he did not make a formal recommendation. Tr.305-306.

The Cervical Spine:

An MRI of the cervical spine was conducted on May 13, 2000. It indicated a broad base central protrusion at C-4/5 level, measuring 3 millimeters, and another protrusion at the C-5/6 level, measuring 4 millimeters. Tr.233. Dr. Nagelberg testified that a second MRI of the cervical spine, dated February 7, 2001, showed evidence of a mild or three millimeter disc protrusion at C-4/5, with mild effacement of the spinal cord, meaning that the disc is just touching the cord, plus a mild narrowing of the spinal canal. Tr.230. He further testified that the disc bulge at C-5/6 had decreased from 4 millimeters to one millimeter in the February 7, 2001 MRI. Tr.234.

Dr. Nagelberg explained that this mild effacement at C-4/5 may cause pain to radiate into the upper extremities. He opined that Claimant's arm pain may be due to this disc abnormality. Tr.231. He then explained further that "not all of those complaints are explainable by this disc abnormality. Certainly neck pain and upper back pain would be, but a severe degree of numbness and tingling I don't think is completely – is really explained by the disc abnormality.[15] And may be, perhaps, more

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[13]Claimant testified that Dr. Nagelberg informed her she required discography in her lower back as well as her neck. When told that Dr. Nagelberg testified that he never mentioned discography to the lower back, Claimant asserted he was mistaken. Tr.1040.

[14]Claimant testified that Dr. Nagelberg told her she required four surgeries – low back, both knees, and neck surgery. When told Dr. Nagelberg denied ever discussing lower back surgery or left knee surgery with her, see Tr.306, Claimant asserted that Dr. Nagelberg's testimony was wrong. Tr.975-976.

[15]Dr. Nagelberg had testified that Claimant complained of numbness and tingling radiating into all of the fingers of her right hand. Tr.335. Claimant testified at trial that she has numbness

explained by the psychological component of her pain." Tr.232. On cross-examination, Dr. Nagelberg reiterated: "and I truly believe, much of her radicular complaints are related to her underlying psychological component of her pain. And I don't think the diagnostic studies would completely explain that." Dr. Nagelberg went on to testify that in order to determine the significance of the disc abnormality at C-4/5, additional testing should be obtained. Tr.255.

On April 20, 2001, Claimant underwent a CT scan of her cervical spine. Dr. Nagelberg explained he ordered the CT because he was looking for a reason for Claimant's upper extremity pain and numbness. He stated that none of the previous scans had really explained that complaint well. Tr.235-236. The CT revealed some mild spurring without significant neural compression at C-4/5. There was no evidence of disc bulge. Tr.236.[16] On cross-examination, Dr. Nagelberg testified that he believes a CT scan is a complimentary study and sometimes shows things that the MRI does not. Tr.258. He stated that based on the MRIs, Claimant is a surgical candidate. Tr.257. He further testified that radiographically, based on the accumulation of studies, Claimant's condition "is not that bad." Tr.263.

The Right Knee:

In a report dated July 13, 2000, Dr. Nagelberg did not list right knee pain as one of Claimant's complaints. On cross-examination, he testified that she was having right knee pain but he did not include it in his report. It was, however, noted in a pain diagram.[17] There is no notation in the report that Dr. Nagelberg examined Claimant's right knee. Tr.286-287. Regarding a report dated August 24, 2000, Dr. Nagelberg testified that he did not list his findings in relation to the right knee. He did not recall if he examined the right knee at all on that occasion. Tr.301.

An MRI of Claimant's right knee, dated December 16, 2000, showed a tear in the right medial meniscus. EX-9, p.34. On June 18, 2001, Dr. Nagelberg performed right knee surgery on Claimant. Tr.225. It was Dr. Nagelberg's testimony that the knee injury was the result of the February 8, 2000 accident. He stated this opinion was based on Claimant's complaints of "pain in her right [sic]"

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and tingling radiating from her neck down her left arm as well. She has that sensation all the time. Claimant asserts she told Dr. Nagelberg about these symptoms. Dr. Nagelberg testified that Claimant never told him she had numbness in her left hand. Claimant disagreed with Dr. Nagelberg's testimony. Tr.1037-1038.

[16]The interpretation authored by Dr. Fann, a radiologist, states: "Minimal posterior osteophytes at C-4/5 without any significant impingement upon the thecal sack," with no findings at C-5/6. CX-42, p.90, Tr.260.

[17]Dr. Nagelberg referred to pain diagrams on more than one occasion, but they are not part of Dr. Nagelberg's reports, nor did Counsel for Claimant attempt to enter them into evidence, and they are therefore not part of the record.

following the initial injury;[18] Claimant's testimony of "sudden worsening of her complaints or onset of knee pain following the traumatic event;" and his findings at the time of surgery. "[They] were clearly related to a traumatic event." Tr.242.

On cross-examination, Dr. Nagelberg testified that a meniscal tear is not necessarily a weight bearing injury. He continued "there must have been some twisting of her knee, or her leg that resulted in an injury to her knee. In addition, as we indicated in the reporting, there was some degree of favoring of the right side, due to the left knee pain that she had.[19] So I think in combination, those two mechanisms together resulted in her–the medial meniscal tear." Tr.316-317.

Dr. Nagelberg thought of this surgery "in a sense, as a test." Tr.294. Dr. Nagelberg opined that because this surgery was successful, Claimant had proven to him that she could benefit from surgery. Tr.265. He testified that he is planning to perform an anterior cervical discectomy and fusion with iliac crest bone graph at C-4/5,[20] because the Claimant has proven her ability to benefit from surgery as a means to combat her pain. Tr.233-235. Dr. Nagelberg stated that no surgery at the C-5/6 level would be done, unless additional testing was positive. He testified that he was considering sending Claimant for a discogram, a test where a needle is placed into the damaged disc, to verify where a patient's pain is coming from. According to Dr. Nagelberg, this is a fairly objective test. Tr.235. He also testified it is an invasive test, and can be very painful if it is positive. Tr.237.

At the time of trial, Claimant had made a total of ten visits to Dr. Nagelberg's office. Out of those ten visits, Claimant was examined by Dr Nagelberg five times. On all other occasions, Claimant was examined by Physician Assistant, Brett Rassmussen. CX-24 to CX-35. Dr. Nagelberg testified that his assistant does the examination. Dr. Nagelberg then reviews the diagnostic studies and the assistant's report and dictates the course of action he feels should be taken. Dr. Nagelberg did not have any dialogue with Claimant on those occasions when his assistant performed the examinations. Tr.285-286.[21]

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[18]Dr. Nagelberg was referring to Dr. Bhalla's report of March 24, 2000. He testified that he did not see any complaint of right knee pain or examinations of the right knee in the reports of Dr. Shea and Kaiser Hospital dated February 8, 2000, or of Dr. Burns, dated February 10, 2000. Tr.325-326.

[19]Dr. Nagelberg testified the first time he noted an overcompensation due to left knee pain was in his December 7, 2000 report. Tr.319.

[20]Dr. Nagelberg described the procedure as entailing "taking out the disc from the front of the neck, using a microscope, and replacing it with a small piece of bone from the pelvis." Tr.234-235.

[21]Dr. Nagelberg testified "What happens is he examines the patient, he talks to me, and I render an opinion." Tr.319.

At trial, Dr. Nagelberg's diagnoses were functional overlay related to psychological component to her pain, residuals of right knee arthroscopy and partial arthroscopic medial meniscectomy, cervical discogenic pain, and low back pain. Tr.229. He opined that Claimant's ongoing temporary total disability is related mostly to her cervical spine as well as her low back pain. Because of this pain, Claimant "is incapable of performing any type of gainful employment," and "if all she had was her knee complaints, she could work in some capacity at this point." Tr.224-225. He stated Claimant "has symptoms in her upper extremities and there is no test for pain. The test that we're going to do for pain is a discogram. This is an objective test for pain. But there is no documentation of radiculopathy." Tr.343. Dr. Nagelberg intends to follow up the discogram with the anterior cervical discectomy and fusion at C-4/5. Tr.342.

Dr. Eugene Freed:

On July 13, 2000, Dr. Nagelberg referred Claimant to Dr. Eugene Freed, an ear, nose and throat specialist, for evaluation of her February 8, 2000, work-related ear injury, CX-26, p. 47;. EX-14, p.144. Dr. Freed examined Claimant on September 25, 2000. He examined Claimant's head and neck which revealed no ear, nose or throat abnormalities, or evidence of disease. Dr. Freed conducted an audiogram which revealed good hearing in both ears, and no abnormal compliance for either ear. He further conducted an electronystagmogram. The results were: no significant gaze, spontaneous or positional nystagmus. A bilateral bithermal caloric stimulation was discontinued due to the onset of nausea. EX-14, p.145-146.

Dr. Freed diagnosed Claimant with post-injury labyrinthitis with moderate tinnitus and minimal vertigo, and post-trauma cephalgia. He stated that Claimant suffered from minimal dizziness and moderate tinnitus, or ringing in her ears. Dr. Freed concluded that these conditions were permanent and stationary residuals of the February 8, 2000 incident. Dr. Freed deferred any opinions of Claimant's headaches to her treating physician. He did not recommend any further treatment for the dizziness and ringing, stating there are no medical or surgical treatments that could improve Claimant's condition. Dr.
Freed imposed no work restrictions on Claimant. EX-14, p.146.

Dr. James T. London:

Dr. James T. London, a board certified orthopedic surgeon, testified on behalf of Employer. See Curriculum Vitae of Dr. London, EX-21, p.758-784. Dr. London examined Claimant twice, first on May 15, 2000, the second examination on March 16, 2001. Tr.410, EX-10, p.38, 51.

At the May 15, 2000, examination Claimant reported the following complaints: constant occipital pain radiating down the posterior neck, into the shoulders and shoulder blade area, tingling over the back of the arms, down forearms, and hands, into ring and small fingers of both hands, pain in the index, ring, and long fingers of the right hand, worse with gripping and holding objects, weakness in right hand, burning pain over left anterior chest around ribs, constant low back pain, radiating into the right buttock and down the right thigh to the ankle, bilateral knee pain more on left

than right, a weak sensation in both knees, as well as grinding, intermittent pain over the medial left foot, radiating into the great toe, pain on the plantar aspect of the second and third metatarsophalangeal joints, worsening with weight bearing, pain in the left anterior neck, and intermittent dizziness. Tr.412, EX-10, p.39-40.

Dr. London reviewed the medical records of Dr. Shea, February 8, 2000; Dr. Burns, February 10, 2000 through February 22, 2000; Dr. Bhalla, March 24, 2000, and Dr. Nagelberg, March 29, 2000. Tr.414, EX-10, p.42-43. Dr. London then examined Claimant. His findings relating to her cervical spine were: normal cervical lordosis, or curvature of the neck. Claimant's active range of motion was restricted to 70 degrees of forward bending or flexion, 20 degrees of extension. Lateral rotation was 60 degrees right, 65 left.[22] On palpation there was tenderness on both sides of the neck area. The foraminal compression test was negative. Joints in the upper extremities had full range of motion. Sensation was decreased over the ulnar aspect of the forearms and the last three fingers in both hands. There was no evidence of muscle atrophy or weakness in the upper extremities. Arm and forearm circumferences were normal, and grip strength was normal. Tr.414-415, EX-10, p.43.

Regarding Claimant's chest, Dr. London found there was no pain with rib compression, and full respiratory excursion without pain. There was tenderness over the entire sternum and both sides of the chest. EX-10, p.43.

Dr. London's findings regarding Claimants thoracolumbar spine were: Claimant's gait was slow, but there were no pathological features to it. Her pelvis was level in stance. Heel-and-toe walking could be performed, but it caused the medial foot pain complained of. Reflexes in the knees and ankles were normal. There was tenderness over the right sciatic notch and from L3 to S1 in the midline. There was additional tenderness over the iliac crest, or brim of the pelvis, extending all the way over to the front of the pelvis, and more from the base of the neck down to the mid-thoracic area, as well as the adjacent paraspinal muscles. This tenderness was not well localized. "In other words, it was more of a generalized tenderness." Tr.416. Straight leg raising test for sciatic nerve irritation was negative bilaterally, and calf circumferences in the lower extremities were normal. Tr.415-416, EX-10, p.44.

The examination of Claimant' lower extremities revealed full range of motion of the joints, and no fluid in her knee joints. Claimant has a scar on the medial aspect of the left patella, and a transverse scar distal to the patella on the left side. There was no crepitation in either knee. The ligaments were stable. Provocative tests for arthritis were all negative. There was no fullness, nor tenderness in the back of the knee. There was slightly decreased sensation over the anterior of the right knee. Sensation of the lower extremities was otherwise normal. The remainder of the examination of the knees was normal. The left foot had no obvious abnormalities. There was tenderness over the medial ligament and the medial aspect of the left foot. Tr.416-417, EX-10, p.44.

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[22]Dr. London opined that "you'd expect more like 80 degrees of flexion, and 30 degrees of extension" and rotation to be "more in the neighborhood of 80 degrees bilaterally." Tr.414.

Dr. London testified he concurred with the opinions of Dr. Shea and Dr. Burns immediately following the injury, that Claimant's injuries were soft tissue injuries. Tr.418. He concurred with Dr. Bhalla's conclusion that Claimant was capable of returning to work as early as March, 25, 2000. Tr.449-450. He stated in his report "I am unable to explain her expanding symptomatology as noted in her medical records." EX-10, p.46. Dr. London elaborated, stating "pain is usually immediate, particularly if you have sustained any sort of an injury of any seriousness." He opined that although it is possible to have a delay in the onset of symptoms after an injury, this is usually the result of a soft tissue straining injury; "a much milder form of injury." These injuries heal "even in the absence of any treatment." Dr. London continued:

> it was difficult for me to understand at the time of my evaluation how someone could have injured, for example, their upper back and lower back and had seen two separate sets of doctors, and they were obviously concerned enough about their health to get a consultation, they didn't register any symptoms in those areas. There were no physical findings in those areas. The doctors didn't do any diagnostic studies, such as x-rays of those areas. They reached no diagnoses referable to those areas. And they recommended no treatment to those areas. It makes it hard for me to understand that she had an injury to her upper back, lower back, and right knee. Tr.421.

Dr. London reviewed the radiology report and the MRI studies of Claimant's cervical spine dated May 13, 2000. He opined there was evidence of degenerative changes in the mid-cervical area. These changes were characterized by irregularity of the bony endplates, as well as bone spur formation. Dr. London explained that when you see irregularity of the bony endplates, that is a sign of a chronic, degenerative change. This was noted at both levels 4 and 5, as well as disc bulges of 3 and 4 millimeters, respectively. There was disc spacing, also a chronic degenerative change which happens to "all individuals over time." Tr.422-424. There was no evidence of nerve root impingement. Tr.426.
Dr. London reviewed the x-rays taken of Claimant's cervical spine on the date of the incident. He noted disc space narrowing at both the C-4 and C-5 level at that time. Tr.426.

His review of the MRI of Claimant's lumbar spine showed no evidence of any nerve root impingement, with normal disc spacing. There was a one millimeter physiological disc bulge at L-5/S-1. Tr.426-427. The review of the MRI of Claimant's left knee showed a metal artifact, from her prior knee surgery, and some Grade II degenerative change in the medial meniscus, but no meniscal tearing. Tr.427, EX-10, p.49-50. After review of all of these studies, it was still Dr. London's opinion that Claimant had sustained soft tissue injuries on February 8, 2000. These injuries should have resolved over time, and Claimant was capable of returning to work. Tr.427-428.

Dr. London was cross-examined on the length of time a soft tissue injury may take to heal. He stated it can take as little as a day, or as much as ten to twelve weeks to heal. Dr. London took exception to the suggestion that the symptoms of a soft tissue injury could go on for years. Tr.485. He testified there is no medical documentation of a purely soft tissue injury taking longer than 10-12

weeks to heal. Tr.486.[23] Dr. London stated that the condition of Claimant's neck was one that included both a soft tissue injury as well as disc protrusion. He opined this type of injury could take longer to heal, but he "wouldn't say a lot longer." Tr.487. Dr. London continued if there were disc damage at the time of injury, acute changes as opposed to degenerative changes as in Claimant's case, healing may be prolonged. He did not, however, see any evidence of that type of injury in this case. There was no additional damage done to the discs in Claimant's cervical spine in the February 8, 2000 incident. Tr.493-494.

Dr. London re-examined Claimant on March 16, 2001. At this time, Claimant's complaints were: headaches in the back of the head, coming around to the temporal areas, worse when walking, better with lying down. Her head felt heavy. Pain over the posterior aspect in both sides of her neck, radiating up into the head and down into the mid-back area, worse on the left than right. It also radiated into her arms, onto the dorsum of both forearms, and into her thumb, index, and long fingers of the right hand. She had similar pain radiation on the left side. The pain could spread and become more generalized. She had intermittent numbness in her right upper extremity, in the same distribution as her pain. Claimant suffered from weakness of grip in her right hand, describing it as a bouncing feeling when holding objects. Tr.429-430, EX-10, p.52-53.

Claimant complained of frequent pain over the anterior of the chest in the area of the breast bone, spreading to both sides; worse if she was reaching overhead. She complained of constant pain in the front of her neck, the left inferior breast area, and left anterior lower ribs. She had a feeling that something was loose in that area with forward bending. Claimant had constant low back pain that radiated into both buttocks and down into her hips. She had burning pain over the right lateral and anterior thigh, down the right lower leg, into the right foot and the right second toe; worse with weight bearing. She had constant bilateral knee pain, distributed all around the distal thigh, knee, and proximal lower leg. The pain was worse with standing and walking. She had a painful mass on the front of her right tibia, the shin area, which she pointed to at the insertion of the patella tendon, noted as the tibial tubercle. Claimant had weakness in both knees, a kind of giving out, a locking of her left knee that was associated with pain, grinding in both knees, pressure pain over the right lateral, lower leg, and sharp pain on the planar aspect of the second, third, and fourth metatarsophalangeal joints of the foot, worse with walking or standing. Tr.430-432, EX-10, p.53-54.

At this time, Claimant was taking 800 milligrams of Ibuprofen, three to four times a day, for pain, and Wellbutrin, 100 milligrams, three or four times a day for depression. Tr.434. Dr. London saw no record of any other medication for Claimant's pain. He opined that based on Claimant's litany of complaints, it would be appropriate for Dr. Nagelberg to prescribe some type of analgesic pain killer, instead of merely an over-the-counter anti-inflammatory. Dr. London explained that an analgesic would be more appropriate for the relief of severe pain than would Ibuprofen. He did note that some people do not like to take pain medication. Tr.435, 498-499. On cross-examination, Dr.

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[23]Dr. London differentiated between purely soft tissue injuries and those involving ancillary injuries, such as an unstable spine, disc herniation, radiculopathy, fractures, subluxations, and dislocations. Tr.485.

London added: "What would be unusual is for an individual who says that they're getting steadily and progressively worse throughout their body not to want some sort of relief with medication. With pain severe enough to be contemplating operations and discograms and things like that." Tr.498-499.

Dr. London again reviewed all of Claimant's medical records, including those of Dr. Halote, a psychologist; the electromyogram and nerve conduction studies performed by Dr. Meredith; all MRI studies of Claimant's cervical spine, lumbar spine and right knee; reports by Dr. Valdez of the epidural steroid injections Claimant received; a report by Dr. Eugene Freed, an ear, nose and throat doctor; Dr. Nagelberg's subsequent reports, as well as the reports by Dr. Jerome Franklin, a psychiatrist. EX-10, p.54-60.

Dr. London testified that the nerve conduction studies and electromyogram were within normal limits. He stated these studies ruled out radiculopathy and acute denervation as causes for Claimant's pain. Dr. London stated that Claimant's complaints of pain emanating from the neck and down into the hands could be characterized as radicular, but the distribution of pain was unusual. Dr. London opined that Claimant's "glove-like" pain or numbness in her hand does not really follow a dermatomal distribution. "In other words, it doesn't follow the area of innervation of any particular nerve. It crosses over several nerves." Anatomically, it makes no sense. Tr.436-437.

Dr. London stated that the MRI scan of Claimant's cervical spine dated February 7, 2001 showed no evidence of nerve root compression. He saw nothing that could be responsible for Claimant's radicular complaints. Tr.438. Dr. London explained: "the abnormalities that we are dealing with here are at C-4/5 and C-5/6. The C-4/5 disc would pinch the C-5 nerve. The C-5 nerve goes to the shoulder and the outer aspect of the upper arm. The next disc down, C-5/6, if there was nerve root impingement – which I didn't see – but if there was, it would impinge on the C-6 nerve. The C-6 nerve runs down and goes into just the thumb." Tr.439. Dr. London testified that neither of these discs would explain the symptoms Claimant experienced in the index, long, ring, or small fingers of her hands, nor could they explain a weakness of grip. Tr.439.

Dr. London testified that the CT scan of Claimant's cervical spine dated April 20, 2001 reinforces his opinion. There was no evidence in the scan of any disc pathology such as a bulge, protrusion, or herniation. It merely showed the bone spurs, also found on the MRI studies. Tr.440-441.

Dr. London's examination of Claimant's knees showed a full range of motion and extension to 135 degrees bilaterally. The ligaments were stable. There was no effusion, or extra fluid in the joints. There was diffuse tenderness over all aspects of both knees, starting above the knee cap, over the distal thigh, and extending down to the mid-third of the lower leg. The tenderness was not localized and involved a diversity of anatomic structures. Tr.448, EX-10, p.61. Dr. London testified that this was a bothersome result. The tenderness was in an area covering bones, muscles, ligaments, both condyles, the tendons, the tibial tubercle, and the joint lines. "When you have a meniscal tear, you shouldn't have pain over the tibial tubercle, nor in the patella. You would expect tenderness over the meniscus." Tr.448-449. Dr. London indicated the McMurray's and Apley's signs were both

negative bilaterally. Claimant had indicated that her left tibial tubercle was growing and that she had a mass there. Dr. London found no fullness in the back of either knee. There were no signs of atrophy. Tr.449, Ex-10, p.61.

Dr. London testified that the mechanism of injury that occurred on February 8, 2000, could not cause the meniscal tear in Claimant's right knee, which is a weight-bearing, twisting injury.[24] He reasoned that if Claimant truly tore her meniscus in that accident, she would have complained of pain immediately. Dr. London stated that the meniscus is a very tough structure, and if she sustained an injury severe enough to tear it, there would be pain, swelling, physical findings, limping, complaining. She did not mention pain in her right knee until she was examined by Dr. Bhalla. Tr.451-454, EX-10, p.62. He further testified that based upon the photographs of Claimant's surgery, CX-74-75, as well as Dr. Nagelberg's surgical report, CX-71, p.628, in his opinion, Claimant's medial meniscal tear was attributable to degenerative changes.[25] Tr.456. He testified on cross-examination regarding the photographs, "if you look at the piece of meniscus that's torn, it has fibers coming off of it of meniscal tissue that would indicate chronicity or degeneration." Tr.464, CX-75. Dr. London opined "if Ms. Cardenaz has a medial meniscal tear in her right knee, it should be treated on a private basis." Ex-10, p.62.

Dr. London testified further by telephone to clarify an issue for the court. He commented that the meniscal tear was not caused by overcompensation for pain in the left knee following the incident, as suggested by Dr. Nagelberg. He reasoned first, that type of injury is one caused by a "true accident," not from an overuse situation. Secondly, Claimant's activity level after the incident would have been far less than normal. Therefore any weight and force applied to her right knee after the accident would be less than before the accident, even if she was favoring the left knee. Third, Dr. London opined that the meniscal tear in the right knee was a degenerative-type of tear, similar to the changes on the MRI of her left knee, dated May 15, 2000. These were classified as Grade II changes, of a degenerative nature, not a traumatic or overuse change. Tr.605-608.

In Dr. London's opinion, Claimant's injuries were soft tissue, involving her neck, chest, left knee, and left breast area. Since that time, she has had an evolution of symptoms spreading to other parts of her body.[26] Dr. London stated in his report that Claimant's test results are "notable for their

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[24]Dr. London explained this is an injury regularly sustained by football players. An individual would be standing with weight on the knee and twisting or pivoting. A tackle to the knee in this position could cause a meniscal tear. It is not an injury due to a direct blow, or traction or pulling. Tr.452.

[25]Dr. Nagelberg's report under 'Findings' reads: "degenerative horizontal cleavage tear, posterior horn, medial meniscus." CX-71, p.628.

[26]As an example, Dr. London notes Claimant's complaint of pain and tenderness in her left foot. On cross-examination, Dr. London testified that there was no mention, nor any diagnostic testing done on Claimant's left foot at the time of the injury. Since then, her complaints have

normalcy." EX-10, p.62. Claimant was capable of working at her usual and customary duties from March 24, 2000, when Dr. Bhalla first released her to return to work. Tr.449-450. From an orthopedic standpoint, Claimant does not require any more medical care and treatment on an industrial basis. Tr.458.

In regards to Dr. Nagelberg's intention of performing discography on Claimant, Dr. London testified he does not agree with that opinion. He reasoned that discography has gone through two waves of popularity and then it died. The most recent wave, in his opinion, coincides with the invention, and distribution of a lot of surgical tools for the spine. Tr.442-444. He also stated "the test is not specific, not sensitive, poorly controlled, done different ways in different places, and if you did it in lots of people you would get lots of different responses." Tr.444-445. Dr. London testified on cross-examination he believes it is unreasonable for Dr. Nagelberg to perform a cervical discogram on Claimant. He does not believe such a procedure would be helpful to her, because of the risk of such a procedure, as well as the fact that the information coming from it is "as often misleading as helpful." Tr.502. He further testified on re-direct that, in his opinion, neither does Claimant require a cervical anterior discectomy and fusion at C-4/5/6 with iliac bone grafting. Tr.518.

When questioned regarding Dr. Nagelberg's diagnosis of Claimant's complaints of numbness and tingling in her extremities as psychogenic overlay, Dr. London stated he did not think Dr. Nagelberg attributed any complaints of the upper extremities to such a diagnosis.[27] He then opined that if an individual did have psychogenic overlay, "that would be the last person in the world you'd want to operate on." Tr.504.

Dr. Ronald Farran:

Dr. Ronald Farran testified on behalf of Employer. Dr. Farran is a board certified neurologist. See Curriculum Vitae of Dr. Farran, EX-21, p.764-766. Dr. Farran examined Claimant on May 16, 2000, and again on March 14, 2001. Tr.757, 771.

At the May 16, 2000, examination, Claimant reported the following complaints: low back pain, across the low back and radiating down the right leg, and up into the upper back. The pain increased with coughing or sneezing or any type of movement. This was Claimant's chief complaint at that time. Tr.761. Her second complaint was neck pain radiating into both arms, specifically the

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grown to include intermittent pain over the medial aspect of the left foot, radiating into the great toe during the May 15, 2000, examination. By the March 27, 2001, examination, Claimant's left foot complaints had evolved to "tenderness of everything from the ankle joint to the tips of the toes – even with light palpation of the skin." Tr.511-513. Dr. London could find no orthopedic reason for such pain that would be consistent with the subject injury. Tr.513. His most probable explanation for this complaint would be secondary gain or faking. Tr.514.

[27]All parties agreed that Dr. Nagelberg did not offer a medical diagnosis of psychogenic overlay in any of his medical reports. Tr.516.

ulnar aspect of the forearms and into the last three fingers of each hand. Tr.761. She described pain in the left knee, and left foot, mainly in the metatarsal area, increasing with weight bearing. Tr.761. On cross-examination, Dr. Farran testified Claimant did complain of generalized headaches, but they did not appear to be very significant. "It seemed to be the type of headache that was just associated with her neck injury." Tr.827.

Dr. Farran discussed Claimant's medical history with her, but at the time of the examination, Dr. Farran did not have Claimant's MRI studies to review. Tr.762. Dr. Farran examined Claimant, noting that Claimant was " a pleasant cooperative female in no acute distress." Tr.764, EX-11, p.67. She was fully oriented. Claimant did not appear to be in any kind of pain. She walked without any impairment of her gait. There was no facial grimacing as if she were in pain, "there was just no demeanor of significant distress." Tr.764. Her memory was intact, affect seemed normal, and there was no appearance of depression or thought disorder, such as delusions or hallucinations. Tr.762. Physiologically, Claimant's cranial nerves were intact. There was significant limitation of movement in her neck. Claimant would guard from any motion, particularly with flexion and extension, and less so with rotation and with lateral flexion. Dr. Farran noted "it seemed like [the neck] was quite severely limited to almost like having meningitis where you can't move your neck at all or there's some fracture or dislocation. I mean it was that severe." Tr.763.

The examination of Claimant's lower back revealed a significant range of motion limitation, particularly extension. Claimant could flex forward though, with fingers reaching her knees. Dr. Farran opined this is probably okay, a little bit limited for someone Claimant's age. Tr.764-765. There was a mild degree of paraspinus muscle tenderness along the lumbar spine, but not to the extent that Dr. Farran would have expected with the amount of limitation in Claimant's movements. It seemed disproportionate. Tr.765.

Dr. Farran did not spend much time on Claimant's knees, as he testified that this is not his area of expertise. In the area of extremities, Dr. Farran did a straight leg raising test. Claimant obtained an elevation of 75 degrees lying down, which Dr. Farran opined is close to normal. Rotation of the hips revealed no hip pathology. Tr.765. In the upper extremities, Dr. Farran noted Claimant appeared to have a tunnel sign in her right wrist. He explained that she experienced electrical-like sensation in the hand when he tapped over the nerve. This could be an indication of a carpal tunnel problem, or it could happen in normal patients. Tr.766.

Examination of the motor system revealed that individual muscle strength was normal, although there was "a give-way ratchet-like of the muscles." Dr. Farran explained that "if there was true weakness there, there would be a smooth loss of resistance to my overpowering that particular muscle. So all of her muscles – it wasn't just isolated to any particular ones – but they all had this particular give-way feeling to them, even though the bulk of the muscles appeared normal and her reflexes were intact." Tr.766. Claimant could stand on her toes and heels without difficulty. There were no signs of functional weakness. Babinski sign was negative, and all sensory exams were intact. Romberg test was negative. Gross and fine motor skill coordination was normal. Tr.767.

Dr. Farran commented in his report that although Claimant complained of pain with some

radicular component, the clinical examination failed to reveal any focal deficit. EX-11, p.68. Dr. Farran explained that he did not feel Claimant had radiculopathy due to this lack of a focal deficit. "There was no reflex change, there was no particular group of muscles that would be supplied by a nerve. When we say radicular, we mean nerve root, either a cervical, [thoracic], or a lumbar. So there were [sic] no group of muscles that loss [sic] their strength. There was no sensory loss in the distribution of a particular nerve root. And there was no reflex loss that would indicate a particular nerve root was damaged." Tr.768. In support of his diagnosis, Dr. Farran conducted electro diagnostic testing on Claimant. He did an EMG as well as a nerve conduction study. EX-11, p.70. The studies were entirely normal. There was no finding of radiculopathy, or of acute denervation in either the upper or lower extremities. TR.769-770.

Dr. Farran's conclusion was that Claimant suffered from a soft tissue injury and a sprain/strain-type injury to the neck and lumbar area. She had a contusional laceration to the left knee as well as contusions to the left chest wall. Tr.767. He opined that, given the fact that the exam and testing was all normal, Claimant could return to her usual work as a UTR operator, without restriction, as of May 16, 2000. Tr.771, Ex-11, p.69.

Dr. Farran re-evaluated Claimant on March 14, 2001. At this time, Claimant's complaints were: bilateral neck pain with radiation into the upper extremities as well as more proximal radiation into the head. Claimant now complained of daily headaches. Claimant was experiencing acroparesthesias,[28] or tingling or numbness that is transient, involving the hands and feet. Tr.775. Claimant now experienced pain in her thoracic spine, with some radiation into the chest wall. She had pain in both knees, but no swelling or redness associated with them. Tr.776. Claimant suffered from low back pain, with radiation into both lower extremities, with numbness in the toes. She was depressed. Claimant told Dr. Farran she was seeing Dr. Swerdlick, a psychiatrist, once a month, and that she was on medication for depression. Finally, Claimant complained she was weak. Dr. Farran testified "it was not specific to any group of muscles, just overall weak in muscles of the arms and legs and hands and feet." Tr.776.

Dr. Farran noted that Claimant showed no signs of being in any pain, although she seemed mildly depressed, even tearful. Dr. Farran's examination of Claimant revealed some improvement in neck mobility, although there was still significant limitation in flexion, extension, rotation, and lateral flexion. Tr.779. There was still some tenderness along the spine, but Dr. Farran judged it as only mild. The muscles along the back of the neck were slightly tender. He stated "again there was a disproportion to the range of motion limitation in comparison to the degree of tenderness." Tr.780. Claimant guarded all movements during the examination. Dr. Farran explained that this meant Claimant would resist or stop him for moving her neck when he tried to do so. Dr. Farran opined that the type of injury Claimant had suffered from should have healed within six weeks, two or three months at most. He found it significant that Claimant was guarding her movements a year later.

[28]Dr. Farran testified that this condition is usually an anxiety symptom. It comes and goes, and is usually related to some anxiety or hyper-ventilation. He stated the complaint was not substantiated by any objective findings on the exam. Tr.778.

Tr.781.

The examination of the low back revealed mild tenderness of the paraspinus muscles and the ligaments between the spinus process. Claimant was able to flex a little better this time. Her fingertips reached to the level of her mid-shin. Lateral flexion had increased to 15 degrees bilaterally, and extension was 10 degrees. Tr.781, EX-11, p.77.

The motor exam showed a ratchet-like giving-way. Dr. Farran testified "the interpretation of that is that the patient is either in a lot of pain or that they're not giving full effort." Tr.782. Dr. Farran noted that when he watched Claimant walk, stand on her toes and heels, and extend her arms outwards in front of her, there was no loss of muscle bulk and impairment of her functional capability that one would expect if a person had the significant type of weakness that Claimant was demonstrating. Tr.782. The usual interpretation of this type of behavior is that she was not giving her best effort. Tr.782. Claimant's reflexes were intact and symmetrical. Plantar responses were flexion bilaterally, meaning there was no sign of any spinal cord dysfunction. Tr.783.

Dr. Farran found Claimant had distal blunting to pinprick and touch, meaning Claimant did not feel the sensation of the pinprick or the cotton on her hands and feet. He referred to this as a "stocking glove loss." All other modalities were intact. Tr.783. Dr. Farran's interpretation of this finding was that it is usually not physiological. It is usually something hysterical, or it is not a real finding. Tr.783-784.

Coordination tested normal. The straight leg raising test in a sitting position was 90 to zero degrees without pain. However, the same test done lying down, while it should reveal the same result, Claimant was positive for back pain at 45 degrees in both legs. Dr. Farran opined that these inconsistencies mean this is probably not a true positive straight leg raising sign, which could be an indication of malingering. Tr.784. Again, Dr. Farran conducted an EMG and nerve conduction study. The results were entirely normal. Tr.784.

Dr. Farran reviewed all of Claimant's MRI studies. He opined the MRI of Claimants cervical spine revealed degenerative changes. There was no compression of any nerve roots, and the bulge appeared to be of little significance at three millimeters. He stated that the presence of osteophytes suggests the condition is degenerative. Tr.787-788. On review of the CT scan report of Claimant's neck, Dr. Farran testified the report supports his position.[29] The scan showed no evidence of any nerve root compression, no impingement of the thecal[30] sack. It seemed mostly degenerative in nature. Tr.801. Dr. Farran testified on cross-examination that it is common for a degenerative change to be aggravated by a trauma. The symptoms of a previous injury may be enhanced. Tr.841.

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[29]It was Dr. Farran's opinion that a CT is better for showing foraminal openings than an MRI. Tr.801.

[30]Throughout the transcript, "thecal" was transcribed as "fecal." This is obviously a transcription error.

It was Dr. Farran's opinion that this was a non-industrial case. It was not that serious an injury, and all of the medical treatment Claimant was undergoing was "going way beyond the need of this patient's injuries." Tr.786. He stated in his report: "I believe that no additional medical care and treatment is recommended. She has received an inordinate amount of treatment through various disciplines without any significant change. . . I would certainly be adamant against any surgical intervention in regards to her cervical and lumbar spine. " EX-11, p.78. Dr. Farran believed Claimant reached a permanent and stationary condition on May 15, 2000. She was capable of returning to her duties as a UTR operator without restrictions. Tr. 789.

When questioned on discography as a diagnostic tool, Dr. Farran testified that "[d]iscography is a tricky thing. I'm still not convinced – and I've talked to a number of neuroradiologists – the interpretation of it is very difficult. It's quite subjective. . . it can be very misleading." Tr.791. Dr. Farran testified that he believed a discography of Claimant's neck would be too confusing. He opined that interpretation in the cervical area is fraught with difficulty. He stated: "I don't think it would answer the question as to whether or not to operate on her at all. I mean, even if it was positive, she had no clinical findings or imaging findings that would substantiate doing any type of surgery of that sort. I just think it would be a big mistake." Tr.794.

Regarding Claimant's complaints of pain radiating into select fingers of her hands, Dr. Farran explained that a disc problem at C-4/5, as in this case, would radiate pain into the upper arm and possibly the thumb. "[Y]ou'd have to have down to C-6/7, C-7/8, in order to get all of those fingers involved. . . So the bottom line, again, is that it doesn't fit." Tr.796. To do any type of surgical procedure "is fraught with failure and disaster." Tr.796.

Dr. Steven Rothman:

Dr. Steven Rothman, a neuroradiologist, testified on behalf of Employer. Tr.358. See, Curriculum Vitae of Dr. Rothman, EX-21, p.769-782. Dr. Rothman reviewed Claimant's MRI scans of the cervical spine, lumbar spine, left and right knee, as well as the radiology reports of Dr. Crues.[31] Tr.361. Dr. Rothman testified that Dr. Crues is an expert muscular/skeletal radiologist. Dr. Rothman fully agreed with Dr. Crues interpretation of Claimant's MRI scans. Regarding the lumbar spine study, Dr. Rothman noted a visible annular fissure or fibrous tissue in the back of a degenerative tear of the disc, with a mild diffused disc bulge. He stated that this is a minor degenerative abnormality and there is no evidence of pressure on any of the nerve roots. Tr.362-363.

Regarding the MRI of the cervical spine dated May 13, 2000, Dr. Rothman testified that the spinal canal is somewhat narrowed, but he did not see any evidence of nerve root compression. Dr. Rothman continued, that the disc between the fourth and fifth vertebrae was bulging all the way across the canal. There were associated small bony ridges. The disc between five and six was also bulging across the canal, more on the midline. Dr. Rothman noted the disc bulges were concentric.

[31]On cross-examination, Dr. Rothman testified that he does not examine patients, he just reads films. Tr.381.

They went all the way across, with some narrowing of the right side of the canal at C-4/5, and slight narrowing at C-5/6. Dr. Rothman opined that he could not say there was no possibility of nerve root irritation, but would expect any irritation to be minimal. Tr.364-365.

Dr. Rothman reviewed the February 7, 2001 MRI of the cervical spine as well. He found it interesting that the annular bulge looked smaller on the second study. Dr. Rothman could not account for why, he stated that does not generally occur. He opined it may be the technique of the scan. Tr.365. He testified that there was narrowing and degeneration between the fourth and fifth vertebrae, and narrowing between the fifth and sixth vertebrae, with bulging of the discs. Dr. Rothman testified that the black area on the study represents degenerative bone in the space on the other side at the level C-5 nerve root. Tr.366. He characterized this as a mild disc bulge, with slight possibility of nerve root compression at C-4/5, due to the bony ridge. Tr.366-367. Dr. Rothman stated on cross-examination that this was moderately permanent degenerative disc disease at C-4/5, and less permanent degenerative disc disease at C-5/6. "It's clearly degenerative." Tr.389.[32]

When questioned about Claimant's complaints of neck pain radiating into the right arm and all of the fingers of the right hand, Dr. Rothman opined that there is a failure of correlation with Claimant's MRI scan. Tr.367. He explained that the only area that may be irritating a nerve would be at C-5/6, irritating the C-5 nerve. The C-6 nerve innervates the thumb and index finger. C-7 goes to the middle finger and the inner portion of the fourth finger, and sometime the fourth and fifth finger. He stated "there's nothing on this MRI scan which would be affecting the fourth and fifth and third finger. It's actually, really, above any of the fingers. I would expect, if anything, would be [sic] pain radiating towards the upper arm." Tr.367-368.

When asked if Claimant's complaint, in her deposition, of pain radiating into all the fingers of her right hand except the index finger is clinically possible, Dr. Rothman responded: "Anything is theoretically possible, but that's very unphysiological. Typically, the index finger is the C-6 nerve root. If it radiates into the thumb and middle finger, it should catch the index finger." Tr.368-369. Dr. Rothman continued by explaining that the fifth finger and the thumb are separated by two whole segments. "One would have to have two discrete lesions at different levels to be causing neural compression." Tr.369.

Regarding Claimant's complaint of pain radiating down her left arm and into the middle and ring fingers of her left hand, Dr. Rothman testified that there certainly was nothing on the February 7, 2001 scan that would warrant such a complaint. On the May 13, 2000 scan, while the disc bulge was more prominent in the center, it was still one level higher than he would expect to cause those complaints. Tr.369. Dr. Rothman opined that the CT scan report supports this conclusion. Tr.371.

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[32]Dr. Rothman testified that the mechanism of injury, regardless of the size of the impact, could not possibly cause anything that appeared on the MRI scans. That would relate to the extent of Claimant's soft tissue injury, not her degenerative disc disease. Tr.392-393.

On cross-examination, Dr. Rothman was asked if he agreed with Dr. Nagelberg's diagnosis of psychogenic overlay to explain Claimant's abnormal pain patterns. He declined to comment. Tr.382. Dr. Rothman was then asked if he would have any quarrel with Dr. Nagelberg doing disc fusion, depending on the results of the discogram. Dr. Rothman stated that if Dr. Nagelberg opined that Claimant's complaints are psychogenic, then "doing spine fusions for psychogenic pain is destined for failure." Tr.384. He explained that neck surgery is almost always elective. The only time it is really needed is if there is an increasing neurological deficit. It is a decision determined on the need for surgery, based on the likelihood that the patient will benefit from it. He stated "the more real the complaints are, the more likely that [benefit] is to occur. The more unreal the complaints are, the less likely that is true." Tr.384. Dr. Rothman stated he was not saying neck surgery is absolutely contrary-indicated in Claimant's case.

Dr. Rothman was asked his opinions on discography. He stated that it is a very controversial procedure. It is totally subjective. He explained that the theory behind discography is that if one injects fluid into a disc, and it elicits the exact pain response the patient has, then one can imply that *that* disc is the generator of the pain. He stated the problem with the theory is that discography in general can be painful. The results are "very much related to the patient's perception of their pain, and the person doing the discogram's perception of that perception. So it really has two different levels of subjectivity." Tr.373. Dr. Rothman noted that there have been recent studies of discograms performed on normal people, with abnormal results. This, to him, showed the subjectivity of the procedure. Tr.373. Dr. Rothman stated:

> [I]f the surgeon does his own discograms, I would give that no credence whatsoever. He's putting the pressure on that needle and he can make that person jump off the table at his whim. So that, I would consider, totally invalid. If a good discographer was doing it – again, it's very subjective. It depends on the quality of the response. Certainly, if one wants to do surgery, one can use that to justify it. Tr.374.

Dr. Rothman further stated on cross-examination, that he read a recent publication that related the results of discography to the psychological state of the patient. Dr. Rothman explained the study concluded that the psychological state of the patient correlates very well with abnormal discography. "If you have a very solid person, the discography is more meaningful. If you don't have a solid person, one whom you believe every one of the symptoms, that makes discography even less reliable." Tr.386-387.

Dr. Rothman was asked if he had a problem with Dr. Nagelberg's plan to do surgery on Claimant's neck. Dr. Rothman responded that he did. He stated:

When I was presented with these films with a history of neck pain and nothing else, I couldn't make a comment, because I had no idea what the clinical signs were. You present me a person who the own treating physician says has psychological overlay, weakening the one objective criteria that you have, and you're presuming that the neck pain is not psychologically oriented and is going to mysteriously get better by doing a spine fusion. Well, if you fused every single person that had a

degenerative spine, nearly everybody over the age of 30 would have a scar on their neck. And not even those with pain. Because here you're saying that the patient has a psychodynamically maneuverable pain. So how do I know that this pain is not real, but this pain is real? Tr.387-388.

Dr. Rothman opined that Claimant's counsel was presenting him with a hypothetical which should be a red flag in the face of any surgeon contemplating surgery. Tr.390.

Regarding the right knee, Dr. Rothman reviewed the reports of Dr. Crues, as well as the December 16, 2000, MRI scan itself. He agreed with Dr. Crues that there was an obvious posterior horn meniscal tear. Tr.376. Dr. Rothman explained how such an injury occurs. He stated that the majority of meniscal tears are the result of longstanding wear and tear on the knees, walking, running, "or doing what people do." Tr.377. He continued that only a minority of injuries result from trauma. Dr. Rothman stated that when the tear is due to trauma, it is usually associated with a major injury "and typically described like a clipping penalty in football. It's a weight-bearing blow to the back or side of the knee, requiring forces of weight-bearing torque upon the meniscus." Tr.377. Dr. Rothman opined, that to a reasonable degree of medical certainty, it would be nearly impossible for Claimant to have sustained a meniscal tear in the accident of February 8, 2000, as it was described to him by Employer's counsel.[33] Tr.378.

Psychological Evidence

Dr. Barry Halote:

Claimant was referred to Dr. Barry Halote, a psychologist, by Dr. Nagelberg. See Curriculum Vitae of Dr. Halote, CX-55, p.132-136.[34] Dr.Halote's deposition was taken on June 20, 2001, and submitted as Employer's Exhibit 26. He testified as follows.

Dr. Halote first saw Claimant on August 25, 2000. At this initial visit, Dr. Halote conducted a clinical interview, lasting approximately one hour. Claimant underwent psychological testing as well, consisting of a Beck depression inventory; Minnesota multiphasic personality inventory, second edition; sentence completion test; Wahler physical symptom inventory; adult neuropsychological

[33]Dr. Rothman described, on cross-examination, his understanding of the accident. He understood that Claimant was banged around inside the cabin of a vehicle, "in a vertical and kind of a complex way," when something hit the back of the vehicle. He testified that the entire scenario, that of Claimant in a truck, and a large container dropped on the back, causing it to lift into the air and slam back down, was described to him. Tr.391.

[34]On cross-examination Dr. Halote stated that all of the articles listed on his C.V. were written in connection with attaining his Ph.D. in 1984. The only other article Dr. Halote has authored since that time, is not listed on his C.V., as he has not updated it. EX-26, p.919.

questionnaire; an SCL-90-R, and a P-3 pain patient profile. EX-26, p.888-889.[35]

Dr. Halote's report, dated September 13, 2000, states Claimant was "a clean, neatly groomed and casually dressed woman."[36] She was "cooperative, yet passive." CX-49, p.111. During the interview, Dr. Halote found Claimant depressed and anxious. He testified that she seemed to be in pain. Claimant was uncomfortable, her body posture was slumped. She was sad and tearful, withdrawn; she reported she was feeling helpless. EX-26, p.890-891. Dr. Halote testified that Claimant complained of difficulty sleeping. She was waking with nightmares. Claimant complained of irritability, forgetfulness, and that her concentration had virtually disappeared. She disclosed suicidal ideation, "but she showed no intent or plan to carry it out." EX-26, p.891.

On cross-examination, Dr. Halote testified he enquired of Claimant how the accident occurred, and how she was feeling. During that hour, he did not talk to Claimant about very many other issues. EX-26, p.924. He did not talk to Claimant about her family situation. Dr. Halote testified "that is not appropriate in workers' compensation at this juncture in the case." EX-26, p.948. At this point Dr. Halote was asked if he was under the impression that this was a State of California workers' compensation case. He stated that he was, but is now learning that he was misinformed. He testified that he did not know the requirements of a federal case, and whether a patient's family situation is necessary information. Ex-26, p.949. Dr. Halote did not talk to Claimant about her reported nightmares. EX-26, p.951. He testified they could be significant, but he does not have enough history on Claimant to make an educated hypothesis on that issue. Again, he was under the impression that all of these issues went to apportionment, which in state cases, is dealt with in the final evaluation, not the initial diagnosis and treatment. EX-26, p.951-953.

Dr. Halote testified on cross-examination that he did not enquire into Claimant's day-to-day activities. He did not know whether she was capable of driving herself to appointments, or whether she was capable of going grocery shopping. This may or may not be important information, "it depends on the degree." Again, Dr. Halote stated he was working under the auspices of the California workers' compensation system, and did not think the questions relevant to the issue of whether Claimant was disabled or not. EX-26, p.987-988.

Dr. Halote noted Claimant's physical complaints as back pain that radiates down her right lower extremity and left knee pain that makes walking difficult. She reported headaches and fatigue.

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[35]Dr. Halote explained the purpose of these tests was to validate his clinical observations, give him other hypotheses to explore, and to validate any conclusions that he may or may not come up with. He stated that he relies on the clinical interview more than he does the psychological testing in making a diagnosis. EX-26, p.889.

[36]Dr. Halote testified on cross-examination that a lack of grooming, a disheveled look, can be a symptom of depression, but "the absence of it does not mean that they are not depressed." EX-26, p.989.

CX-49, p.112. Dr. Halote's report does not state that Claimant complained of neck pain.[37] EX-26, p.940, 942. Dr. Halote clarified that in fact, Claimant did complain of neck pain, "on the psychological testing which you don't have." EX-26, p.941.[38] Dr. Halote also stated there was no mention of right knee pain. EX-26, p.947. Dr. Halote testified he defers to Claimant's physicians in the physiological arena, he merely took the information "as to how her physical complaints might be affecting her psychological." EX-26, p.892. He stated that her mental status was congruent with her psychological and physical symptoms reported. EX-26, p.892. On cross-examination Dr. Halote stated he had not conferred with Dr. Nagelberg to ascertain what Claimant's condition was from an orthopedic standpoint. EX-26, p.922. He testified, "I can find that out from the patient." EX-26, p.923.

Dr. Halote's report then inventoried the psychological testing done on Claimant.[39] Dr. Halote testified that he does not do overall results. He does not talk about each test individually. He stated: "In workers' compensation, it is done regularly, but anyplace else other than workers' compensation usually you put the tests together and come up with an overall hypothesis of what the tests are saying and put them together." EX-26, p.892. Dr. Halote testified that he did not follow his normal and customary practice in workers' compensation cases. He did what is normally done in the field. He asserted that a more complete report comes at the end of treatment. EX-26, p.893.

When asked on cross-examination where in his report he states the results of each individual test, and how the results lead him to formulate his opinions regarding his diagnosis, Dr. Halote responded "I don't do that." EX-26, p.965. He testified that it is not appropriate. He looks for themes throughout the testing – does the same symptomology show up in all the tests. He is looking for a whole picture. He would not say in his report what each of the tests revealed, he would state what all the tests showed together. EX-26, p.966. Dr. Halote agreed that nowhere in his medical report does it discuss the basis of his conclusions by interpreting the test data. When asked by Employer's counsel, "how do I know what the test shows?" Dr. Halote replied "Because I'm telling

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[37]Claimant testified that she told Dr. Halote that she was experiencing neck pain. When confronted with the fact that this information is missing from Dr. Halote's report, Claimant responded, "He probably forgot. . . I told him a lot of things and maybe he forgot." Tr.1214-1215.

[38]Dr. Halote referred to the Wahler physical symptom inventory. EX-26, p.942.

[39]On cross-examination, Dr Halote was asked why he had not turned over the results of his psychological testing to Employer's counsel, pursuant to a federal subpoena. Dr. Halote stated that he has those records in his possession, but will not turn them over to anyone but another mental health professional, or under judicial order. EX-26, p.933-934. Dr. Halote testified that he did use those test results to formulate his opinion of Claimant's condition. Ex-26, p.935. He later agreed to turn the documents over to Dr. Franklin. EX-26, p.941. At the time of trial, these documents had still not been turned over to Dr. Franklin for review. Tr.114. The court, at the time of writing, is unaware if they have, as yet, been turned over.

you and I'm under oath." EX-26, p.967. Dr. Halote testified that, in reviewing his report on its face, Dr. Franklin[40] would be at a disadvantage, not having the benefit of the raw test data. Ex-26, p.974.

Dr. Halote testified that Claimant completed the testing in his office on August 25, 2000. He stated this to the best of his knowledge, based on the procedure of his office. The tests are given, and during that time, Dr. Halote does his one-hour interview. The patient then finishes the testing on their own time. "They are self-administered tests." EX-26, p.936. Dr. Halote then clarified that according to the records, Claimant underwent more testing on September 8, 2000. He then later testified that it is very rare for someone to take two days to finish "because we usually do not let people leave before we finish their tests. We will sit with them and help them. I have people actually read them to them if they are getting tired, to make sure they do." EX-26, p.962.

Dr. Halote reported that an overall assessment of Claimant's testing "indicates that although her MMPI-2 was rendered invalid due to an extremely elevated F-scale score, her other testing reveals that she appears to be in a depressive state." CX-49, p.114.[41] He continued "a possible risk of suicide or self-destructive behavior should be evaluated considering the high level of depression." CX-49, p.115.[42] Dr. Halote's DSM-IV diagnostic impression was major depressive disorder, and post-traumatic stress disorder ("PTSD"). Dr. Halote opined Claimant met five out of the nine criteria for major depression. Claimant was also complaining of flashbacks and fearfulness of the injury; symptoms congruent with post-traumatic stress disorder, "and being part of a physical injury such as that is outside the normal experience of the human being." EX-26, p.894.

On cross-examination, when asked if there is anywhere in his report where he references that Claimant had flashbacks, Dr. Halote stated "No. I just remember that. I just remember the interview." He agreed that part of his diagnosis is based on his independent recollection of Claimant, but his medical report is silent in certain aspects. EX-26, p.985. Dr. Halote admitted that it should have been in his report. EX-26, p.986.

Dr. Halote began treating Claimant by referring her to a therapist "who does the hands-on

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[40]Dr. Jerome Franklin, a board-certified psychiatrist, examined Claimant on behalf of Employer.

[41]Dr. Halote testified on cross-examination that an F score of 120 is invalid. "And when a test is invalid, you cannot make any assumptions from it whatsoever." EX-26, p.963. He explained, the speculation is that this is from the patient responding randomly. Malingering could not elevate the test to that extent. When asked if it is possible that it is the result of malingering, Dr. Halote stated "I can't say, because it is invalid." EX-26, p.964.

[42]On cross-examination, Dr. Halote pointed out where, in the raw test data, he pulled his conclusions from. He used the language of Claimant's responses to the psychological testing in his report. EX-26, p.968, 977, 981-982.

psychotherapy for most of [his] patients," Adele Latrell, a marriage and family therapist.[43] Claimant sees Ms. Latrell once a week. He testified that he and Adele consult on a regular basis about how Claimant is doing. EX-26, p.895. Dr. Halote also referred Claimant to a psychiatrist, Dr. Peter Swerdlick, for medication for her depression. She is currently taking Wellbutrin, an antidepressant. EX-26, p.899-900. Dr. Halote sent Claimant for biofeedback therapy as well. EX-26, p.992.[44] Dr. Halote testified that Rita Terazon, who administered Claimant's biofeedback therapy, reported on April 10, 2001, that Claimant "seems to have achieved maximum benefit from the biofeedback therapy." EX-26, p.1008, EX-15, p.240. Claimant has not attended a biofeedback session since that date. EX-26, p.1009.

Other than the initial visit, Dr. Halote testified he has seen Claimant twice, for a period of approximately 10-15 minutes each. EX-26, p.896. Dr. Halote testified that one of these visits was four months previous, approximately February, 2001. The purpose of the visit was to "refresh myself on how she is doing, to sort of make contact with her." EX-26, p.896. He opined she was still depressed, anxious, still in pain. He felt that she was still in need of weekly counseling at that time. Ex-26, p.896. The second 15 minute visit was two weeks prior to the deposition. The purpose of that meeting was "just to refresh my memory on what is going on with her. I knew there was a deposition coming up and I wanted to make sure that I was appropriate with my knowledge of the patient." EX-26, p.897. On cross-examination, Dr. Halote testified that he had spent a total of one and a half hours with Claimant since he commenced rendering treatment to her on August 25, 2000. EX-26, p.921.

Dr. Halote testified on cross-examination that he has authored only one narrative report regarding Claimant's condition. He stated that he will not author another narrative report until she has reached permanent and stationary status. EX-26, p.993. Dr. Halote testified that he fills out a two-page report entitled "State of California Treating Physician's Determination of Medical Issues" every 45 days. This form has no headings for 'history', 'complaints', 'examination', or 'mental examination'. Nor is there contained in any of the reports, any objective evidence to substantiate medical findings. Dr. Halote explained: "In psych there is rarely, if ever, objective findings to substantiate medical evidence. I mean we don't know someone is having hallucinations unless they tell us." EX-26, p.1011.

Dr. Halote opined Claimant was improving with the weekly counseling, but slower than he would like. She is still depressed and anxious, has some sleep problems, but does not have the same

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[43]Dr. Latrell is a licensed marriage and family therapist, with a masters' degree, not a PhD.

[44]When questioned as to when the therapy sessions began, Dr. Halote checked his billing records and testified that psychotherapy began on November 3, 2000. Biofeedback began on December 12, 2000. EX-26, p.996. Dr. Halote was then shown an earlier bill, at which time he corrected his testimony. Psychotherapy began on September 8, 2000. EX-26, p.1002. Biofeedback began on August 29, 2000. EX-26, p.997.

problems as she originally had to the same degree. EX-26, p.898. Dr. Halote further opined that Claimant's psychological condition rendered her temporarily totally disabled, but not permanently so. Dr. Halote stated he had not done a thorough enough evaluation to come to any conclusion as to Claimant's possible permanent disability. That is the purpose of his final evaluation. EX-26, p.898. He testified that this would happen once her physical disability stabilizes. "[I]f her physical disability improves greatly, then her psychological condition will also improve greatly. If it does not, there will be less ability to become better." "Her psychological problems are an outgrowth of her physical problems." EX-26, p.899.

When questioned regarding the reports of Dr. Franklin, Dr. Halote disagreed with a number of his findings. Dr. Halote testified that Dr. Franklin made a very large miscalculation in his review of Dr. Halote's psychological testing. Dr. Franklin stated that because Claimant's F-scale was over 120, Dr. Halote should have looked into the possibility of malingering. Dr. Halote opined that such a score is not a sign of malingering, it invalidates the whole test. One cannot draw any conclusions from the MMPI if it is over 120. "F 120's are a sign of random answering more than anything else." EX-26, p.902. Dr. Halote had a problem with this, because Dr. Franklin gave a diagnosis of malingering with no objective justification. He surmised that Dr. Franklin made this diagnosis from the testing. EX-26, p.902-903. Dr. Halote further opined that the literature says psychiatric evaluation without psychological testing tends to be "wanting or insufficient, because you don't have any objective backup to substantiate what you think. . . " EX-26, p.903.

Dr. Halote summed up that he disagrees with Dr. Franklin's diagnosis of malingering because Claimant "does not show any signs of malingering. She wants treatment. She is not saying, 'I want a settlement. Let's get the case over to settlement.' She is cooperating with treatment. She wants treatment." EX-26, p.903-904. When asked if a malingerer would subject herself to unnecessary surgeries, Dr. Halote responded "it has been known to happen to increase the value of a case, but it is rare." EX-26, p.904. Dr. Halote testified that when he talked to Claimant, she wanted to go back to her regular job as a truck driver, if she could. She made good money at it. EX-26, p.907. Later, on cross-examination, Dr. Halote stated that the two times that he saw Claimant, he did not ask her if she wanted to return to work. EX-26, p.1014.

Dr. Halote noted the rest of his criticisms of Dr. Franklin's reports. He stated: "basically, I find the history to be rather sparse." EX-26, p.904. He continues that there is nothing on Axis II[45]

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[45]The DSM-IV uses a multiaxial classification system. This system involves an assessment on five axes, each of which refers to a different domain of information that may help the clinician plan treatment and predict outcome.

The five axes are: I – Clinical disorders
II – Personality disorders
III – General Medical Conditions
IV – Psychosocial and environmental problems
V – Global assessment of functioning

to substantiate a diagnosis of mild histrionic personality traits. Dr. Halote also felt that it was outside Dr. Franklin's area of expertise to discuss "the appropriateness of Claimant's physical injury." "He should not be commenting on anything to do with [Claimant's] orthopedic injury." EX-26, p.905. Dr. Halote stated Dr. Franklin's report is contradictory. Dr. Franklin diagnoses a mood disorder due to her physical injury, and yet states that there is no evidence of a permanent psychiatric disability that is industrially related. Dr. Halote opined that if Claimant's physical injury does not stabilize and subside, then she will probably always be depressed. EX-26, p.905.

Dr. Halote found fault with Dr. Franklin's observation that there was nothing in Claimant's objective appearance to substantiate her subjective complaints. Dr. Halote explains: "a lot of people are able to put on a face for a while, especially since she is Hispanic and they tend to do that. So, therefore, just because she does not look depressed doesn't mean that she is not depressed." EX-26, p.906. In order to determine what is behind someone's face, one must do appropriate psychological testing. EX-26, p.906. Dr. Halote found fault with Dr. Franklin's observations of Claimant during their sessions, especially Dr. Franklin's statement that he would not consider Claimant a serious suicidal risk. Dr. Halote reasons that Claimant was reporting that she wanted to kill herself, that she "completely lost it" during the interview, and that Claimant was hospitalized after this, "so [Dr. Franklin] was off there." EX-26, p.908-910. Dr. Halote testified "if somebody is still in pain for their physical injury and they are suicidal, treatment makes sense to me. Without it, there is a possibility she might end up acting on her suicidal impulses." EX-26, p.911.

Regarding Dr. Franklin's statement that Claimant would be able to perform her usual and customary duties from a psychological standpoint, Dr. Halote responded "Here we have a lady that is a truck driver. She has to drive the freeways with an 18-wheeler. She is depressed, she is anxious and she is crying. I don't want to be in front of her if she has to stop suddenly. Rather dangerous, it seems to me, to have somebody that is depressed, anxious, crying, suicidal, driving a truck on the freeway." EX-26, p.911. On cross-examination, Dr. Halote agreed that his understanding of what Claimant's job entailed was incorrect. Claimant is not allowed to leave the terminal. Dr. Halote responded he still wouldn't want her driving if she is suicidal. EX-26, p.939.

When questioned regarding Claimant's recent psychotherapy sessions, and whether she is still complaining of depression, Dr. Halote stated "I think she has improved to some extent, but the main issue seems to be – rather than depression, seems to be anxiety." EX-26, p.1015. Upon reviewing Ms. Latrell's reports from April to June, 2001, Dr. Halote notes that on April 27, 2001, Claimant had not experienced any suicidal ideation, which Ms. Latrell attributed to her medication. Nor has Ms. Latrell reported that Claimant complained of forgetfulness or nightmares recently. Ex-26, p.1015-1016. Dr. Halote agreed that he has delegated a certain aspect of the treatment of Claimant to Ms. Latrell and Rita Terazon. He relies upon the information that they report to form a well-reasoned opinion as to Claimant's status. EX-26, p.1016-1017.

College Hospital Records:

Diagnostic and Statistical Manual of Mental Disorders, 4th ed., 1994, p. 25.

The records from Claimant's stay at College Hospital were submitted on behalf of Claimant as CX-59, p.156-262. Claimant was admitted to College Hospital on February 21, 2001, after an episode at her deposition. CX-59, p.161. She reported extreme anxiety, anger, depression, uncontrollable crying, as well as "severe nightmares, and auditory and visual hallucinations that seem to be even more intense than previously." CX-59, p.161. The mental status examination on that date states:

> The patient was a mildly disheveled patient who came to the session with no difficulty. She was crying and quite restless during the session. She was oriented to time, place, person and situation. Eye contact was good. Her speech was clear and understandable. The stream of her thoughts was within normal limits with no evidence of loose associations or flight of ideas. The content of her thoughts was coherent, but somewhat hopeless. Reality testing was impaired. She had auditory and visual hallucinations. She denied acute suicidal ideation, but stated that she has had recurrent suicidal ideas to kill herself in order to stop the pain. . . Concentration was fair. Abstract thinking capacity was intact. Insight was fair. Judgment was fair-to-good. CX-59, p.161-162.

Dr. George Dubin's diagnosis was Axis I: major depression, severe, with mood-congruent psychotic features. Rule out post-traumatic stress disorder, panic disorder; Axis II: Deferred; Axis III: deferred to internist; Axis IV: severity of psychosocial stressors: moderate to severe. Work injury. Inability to work. A treatment plan of hospitalization, milieu and group psychotherapy, psychotropic medication, physical examination, and psychosocial assessment was ordered. CX-59, p.162.

Claimant was released to return home on February 23, 2001. Claimant was not suffering from suicidal ideation or hallucinations at that time. CX-59, p.186. Claimant was readmitted later that day, when she became angry and anxious again. CX-59, p.192. At this time, Claimant denied experiencing hallucinations. She denied active suicidal desires. CX-59, p.192. Dr. Maurice Black made a similar diagnosis as that of Dr. Dubin, and ordered hospitalization for safety and stabilization, therapy, and Zyprexa,[46] as "she indicated she still has a few hallucinations." CX-59, p.193. The estimated length of stay was five to seven days. CX-59, p.193.

Claimant was a patient at College Hospital for ten days. She was released on March 3, 2001. CX-59, p.189. At the time of her release, Claimant had a "reduction in [her] agitation and fearfulness, a resolve of depressed mood, to the point where she was no longer acutely psychotic or suicidal and felt to be stable for discharge home." CX-59, p.191.

Dr. Jerome Franklin:

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[46]Zyprexa (olanzapine): a psychotropic medication, used for the short-term treatment of acute manic episodes associated with Bipolar I Disorder. See, Food and Drug Administration Drug Approval web site, www.fda.gov/cder/approval/z.htm.

Dr. Jerome Franklin testified as an expert, specializing in the area of psychiatry, on behalf of Employer. He is a board-certified psychiatrist. Tr.85. See Curriculum Vitae of Dr. Franklin, EX-21, p.767-768. Dr. Franklin examined Claimant on December 19, 2000, and again on March 20, 2001. EX-12, p.92-129. He spent a total of approximately four hours with Claimant, over the course of the two examinations. Tr.130.

Prior to his appointment with Claimant, Dr. Franklin reviewed the medical records in the case, including the initial hospital reports, Dr. Burns' report, Dr. Bhalla's report, those of Dr. Nagelberg, Dr. Halote, Dr. London, Dr. Farran and Dr. Freed. EX-12, p.93-96.

In his first report dated December 19, 2000, Dr. Franklin noted that Claimant was 50 minutes late for her appointment. She arrived accompanied by a woman from her attorney's office, Marilyn Thomason, who sat in on the first examination. Dr. Franklin did not remember Ms. Thomason being intrusive. Tr.90. Dr. Franklin noted that Claimant was nicely dressed in jeans, a denim shirt, and a green sweater, her hair was short, and neatly combed. She wore very little make-up. Dr. Franklin noticed no deterioration of Claimant's personal grooming or hygiene. Tr.91. She even plucked her eyebrows. Tr.94. Dr. Franklin testified that he thinks these observations are very important because "it shows how the person is functioning in their daily life, as opposed to their being withdrawn, poor hygiene, showing no interest in themselves." Tr.92.

Dr. Franklin stated that Claimant did not appear to be in any acute distress. He explained "I'm looking to see how somebody walks into the office, how they sit, whether they have difficulty getting into the chair or out of the chair, whether there's any grimacing or moaning or any type of overt indication that they're in pain." Tr.92. Dr. Franklin noted in his report that Claimant sat in a chair "which is usually spurned by most people with back symptoms." EX-12, p.97. It was not a hard backed chair, but soft and comfortable. Claimant sat in this chair for a prolonged period of time, without appearing restless, never standing or walking about the room. She got out of the chair with ease at the end of the interview. Tr.92, EX-12, p.97.

On cross-examination, Dr. Franklin testified that he did not offer Claimant a hard-backed chair, although one was available. He did not find Claimant's choice of chair to be psychologically significant, he was merely commenting that usually, people with back problems will not sit in that soft chair. Tr.165. He stated he does not offer patients an alternate chair, he waits for them to request one. Tr.166. When asked if perhaps there could be some cultural factor at work to explain why Claimant may not have asked for a different chair, Dr. Franklin responded "That could be, except that I've had experience with Hispanics and if they are hurting, they won't sit in the chair. They'll ask me, and I'll give it to them." Tr.166.

Claimant made good eye contact, and was responsive to questions. She talked very softly, but was otherwise cooperative. Claimant spoke in English, and Dr. Franklin had no difficulty

understanding her. Tr.93. Dr. Franklin noted that Claimant did begin crying during the interview,[47] but by the end she was more relaxed, and she stopped. Tr.94. To Dr. Franklin, this behavior was indicative of someone with mood swings, in other words, not constantly depressed. Claimant complained of difficulty concentrating, but Dr. Franklin did not notice any problem during the interview. Tr.94. Claimant gave a history of the accident, as well as the medical treatment she had undergone, and how she felt it was helping her. Tr.96, EX-12, p.98.

Dr. Franklin gave Claimant an opportunity to describe her physical and emotional symptoms and complaints. Claimant reported to Dr. Franklin that she suffered from "total body pain." Tr.96-97. She indicated she had pain in her neck, low back, spine, knees, hips, feet, shoulders, chest, throat and head. Tr.97, EX-12, p.99. Regarding her emotional complaints, Claimant told Dr. Franklin that she was experiencing anger and hate. She was angry at her daughter, she was angry with her family. She wanted to kill herself. Claimant told Dr. Franklin about some of the dreams she was having, about killing her granddaughter, and a baby in a dark hole and a dog. She stated she woke up scared. She saw red for two days. She thought everything was burning. Tr.98-99. Dr. Franklin commented that these complaints seemed somewhat bizarre to him. Those were rather strange, unusual statements. He testified "It's very rare, if ever, that I hear that type of statement." Tr.99.

Claimant reported to Dr. Franklin that she was having a great deal of difficulty sleeping. She had trouble falling asleep, and would be awakened by nightmares throughout the night. Claimant told Dr. Franklin she never slept more than four hours a night, and did not nap during the day. Tr.101.

Dr. Franklin asked Claimant about her daily activities. She stated that she drives a car, but that a friend drove her to the appointment that day. She told Dr. Franklin that she drives to other appointments, and to do her regular chores. Claimant said she walks to the grocery store to do her shopping. She is able to cook, wash dishes, vacuum, and make beds. Her daughter does the laundry. Tr.102. Dr. Franklin testified that he asks these questions to get an idea of what somebody does during the day, how they spend their time. It appeared to Dr. Franklin that Claimant was engaging in normal day-to-day activities. Tr.102.

Dr. Franklin asked Claimant to describe her interactions with others. She told him that she gets along well with her neighbors. She has a male friend that she speaks with on the phone, and sees twice a week, as well as a close girlfriend that she speaks to twice a week. Tr.103. Claimant described her mood as down. She stated it had pretty much stayed the same, and she was crying on a daily basis because of what happened to her. Claimant told Dr. Franklin that she was sometimes afraid that she would go to sleep and never wake up. She admitted contemplating suicide two months after the accident. She had parked on the edge of the freeway to think about it, but changed her mind. Claimant told Dr. Franklin that she still thought about suicide, but not with the same intensity as before. Tr.103.

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[47]Dr. Franklin noted that it was when Claimant discussed how her acupuncturist asked her about insurance payments that she began crying. Tr.96.

Dr. Franklin took a complete history from Claimant, including where she was raised, her schooling, job history, marital history, family, medical, surgical and psychiatric history, as well as the accident itself, and everything leading up to the interview. EX-12, p.101-106.

Dr. Franklin then evaluated Claimant's mental status. He found her to be an alert, well-oriented woman, verbal, and completely cooperative. He stated that her mood was congenial, and her affect was appropriate to her mood. She began the interview sad, tense, and began to cry, but by the end she had calmed down, and seemed much more relaxed, and not so depressed. Dr. Franklin noted that Claimant did not have any objective signs of insomnia. She did not yawn or sigh. She did not have circles around her eyes.[48] Dr. Franklin also noted no pain behavior. He stated there was no psychomotor retardation but she was mildly agitated for a short period of time. Dr. Franklin did not find Claimant to be a serious suicide risk. Tr.106-107, EX-12, p.106. Dr. Franklin testified that Claimant had no psychotic thought processes, she was not acting in a bizarre fashion. Tr.107.

Dr. Franklin's diagnosis at this time was Axis I: mood disorder due to orthopedic condition as well as possible malingering; Axis II: histrionic personality traits; Axis III: alleged work-related injury February 8, 2000. Dr. Franklin explained that he diagnosed her mood disorder as one resulting from her specific physical injury, as opposed to life events and other circumstances or recurrent major depressive disorders. Tr.108. Regarding his diagnosis of possible malingering, Dr. Franklin explained that although he does not like to make such a diagnosis, he hypothesized it "because there seemed to be such a discrepancy between the mechanics of the injury, from what I was reading in the medical reports, and the list of continuing symptoms that was being elaborated." He stated this was a working hypothesis, an impression he had. Tr.108-109. It was not his opinion to a requisite degree of professional certainty. Tr.192. Dr. Franklin testified that the diagnosis of histrionic personality traits suggest someone who expresses themself in a somewhat dramatic way. He stated that Claimant was certainly very dramatic in describing her symptoms, as well as "her crying, and her whole emotionally labile behavior." Tr.109. Dr. Franklin opined that there was nothing in Claimant's objective appearance that would substantiate any of her physical complaints. Tr.109. This diagnosis of histrionic personality traits was also not one Dr. Franklin held to any degree of professional certainty. Tr.193.

When asked if he thought Claimant should undergo psychiatric treatment, Dr. Franklin stated "probably yes, but it would depend on what that was. I mean there's treatment and then there's treatment." He continued that he was unable to observe any significant change in Claimant, based on what she told him, from the treatment she was receiving at Dr. Halote's office. Tr.110. Dr. Franklin stated that Claimant has told him she would be able to go back to work, if her physical condition improved. He agreed that Claimant was able to work from a psychological standpoint. Tr.110-111.

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[48]On cross-examination, Dr. Franklin was asked whether there was any medical significance to Claimant's subjective symptoms of difficulty sleeping. Dr. Franklin responded: "Well, in view of the fact that her own psychiatrist is not doing anything about insomnia leads me to believe that it's not a serious problem." Tr.214.

Dr. Franklin opined that Claimant did not sustain a psychological injury on an industrial basis. Tr.111.

Dr. Franklin further opined that the medical treatment Claimant was undergoing was deleterious to her. He stated "it was obvious that the treatment she was receiving was not making her feel any better. And I felt that continuing that treatment was just going to continue this belief that she had a serious illness. Which, according, at least, to the medical file that I reviewed, she didn't have. So the longer that went on, the longer she was going to consider herself as being sick." Tr.112. He believed that the treatment would actually be counter-productive. Tr.112.

Dr. Franklin re-examined Claimant on March 20, 2001. At that time, Dr. Franklin reviewed additional medical records, both orthopedic, and psychological. Tr.134. At this examination, Claimant was an hour early, and she arrived with her daughter. Tr.135. Dr. Franklin noted, again, Claimant was nicely dressed, her hair was nicely combed. He observed that Claimant was not wearing make-up such as lipstick, or rouge, but he did notice that "she had paid considerable attention to her eyes." Tr.135. When asked to explain, Dr. Franklin stated, he could not recall if Claimant wore eye makeup, but he did recall she plucked her eyebrows. Tr.136. Dr. Franklin opined that this shows Claimant is interested in her life. She is putting herself together, and is not completely withdrawn and disinterested. Tr.135.

Dr. Franklin testified that Claimant did not appear to be in any acute distress at this time. He did not observe any type of pain behavior. Claimant did not walk with an altered gait. She had no problems walking. Claimant sat in the same chair, and did not appear to have any difficulty sitting through the two-hour exam. Tr.137-138. Claimant was very friendly, smiling. Dr. Franklin noted Claimant looked much improved over the way she was when he first saw her. Tr.138. There was no evidence of any memory impairment. Dr. Franklin testified "as a matter of fact, I pointed out that she was very well-organized. She brought a paper with her that had a list of the doctors she was seeing, as well as all the medications and dosages. And she seemed to pretty well know what she was doing." Tr.138.

Dr. Franklin testified that Claimant still complained of being angry. She told him she was always thinking about the pain, and the stress, and it made her cry. She did admit to feeling calmer, and Claimant felt the medication was helping. Her physical complaints were pain in her neck all the time, headaches, feet numbness, pain in both knees. Claimant stated when she lifted her arms, it hurt her chest and her ribs. EX-12, p.120. Dr. Franklin reported Claimant was eating two meals a day and she had gained a few pounds. EX-12, p.121. The significance of this was that people who are severely depressed generally have either severe weight loss, or severe weight gain. Dr. Franklin opined that this indicated Claimant was eating well. Claimant thought it may have been due to the medication. Tr.140, EX-12, p.121.

Once again, Claimant told Dr. Franklin she was having somewhat bizarre dreams. She told him her dreams frightened her. Somebody was flying, with long nails, and he was trying to get her. She kept running, and then she would wake up. Tr.140-141. Claimant reported a dream about her

granddaughter in which she was driving a jeep and she hit a hole. Her granddaughter's face was cut, and Claimant woke up crying. Tr.141. On cross-examination, Dr. Franklin reiterated his position on Claimant's nightmares: "When I hear somebody having the kind of bizarre dreams that she's describing, to be honest with you, I discount them. I mean, to me that's part of this concept of histrionics." Tr.217. Claimant did not report any flashbacks of the February 8, 2000 incident. Tr.141.

Dr. Franklin again asked Claimant about her daily activities. She told him she enjoyed watching the news, and the Lakers games. Dr. Franklin stated that this would indicate Claimant "was not significantly depressed, because people who are significantly depressed don't do these things." Tr.142. Claimant told Dr. Franklin that she tried to walk every day. He explained this showed Claimant was taking an interest in herself, she was getting out of the house. Dr. Franklin opined exercise is also good for one's mood. Tr.143. Claimant reported that her mood was up and down and she was feeling calm when she saw him. Claimant complained of some sadness regarding the insurance company and what they were going to do, as well as what her doctor would tell her about surgery. Claimant admitted to Dr. Franklin that she was less depressed than in the past, but that she was still crying on a daily basis. Tr.144. Dr. Franklin testified that Claimant told him "there was nothing that her emotional state would keep her from doing at work." Tr.144, EX-12, p.124.

Dr. Franklin found a lot of improvement in Claimant's mental status at this visit. He stated "she was nowhere near as emotionally labile as during the first evaluation. As I mentioned she only came close to tears once, and that's when I asked her about suicidal ideation. She was much better." Tr.145. On cross-examination, Dr. Franklin added that when he asked Claimant about being suicidal, she denied it, stating "I think, but I try to be strong." Tr.167. Dr. Franklin formulated the same diagnosis as the first evaluation. "Nothing changed." Tr.145. Dr. Franklin felt that Claimant, unquestionably, had an emotional response to the physical injury, but did not sustain any permanent injury from a psychiatric standpoint. Dr. Franklin opined that Claimant was permanent and stationary as of the second examination. He did feel Claimant had gained some benefit from the psychotropic medication, and would probably gain more benefit from returning to work. Tr.147-148.

On cross-examination Dr. Franklin clarified his position on whether he thought future psychiatric treatment would be helpful or detrimental to Claimant. He stated that if he had seen some improvement, he would say it would be helpful to continue, but from all that he observed, the treatment was just reinforcing in Claimant the feeling that she was sick. Tr.181-182, 188-189. Dr. Franklin opined that if anything, Claimant should continue the medication. It was the only therapy that he could see she was getting any benefit from. He stated: "as nice as it is and as pleasant it is to talk to somebody, if I don't see results, what's the point of [psychotherapy]?" Tr.189. His recommendations were, possibly continued drug therapy, and if it's the right therapist, psychotherapy might be helpful. Tr.190.

Dr. Franklin testified that he reviewed Dr. Halote's September 13, 2000, report, the reports of Dr Halote's staff, and the transcript of Dr. Halote's deposition. Tr.114. Dr. Franklin stated he did not receive the battery of diagnostic testing administered to Claimant. He opined that the

documents would be helpful, but he did not think it would change his diagnosis. Tr.116. Dr. Franklin testified that from reading the transcript, it appears that he and Dr. Halote disagree "on just about everything." Tr.117. Dr. Franklin opined he thought the report rather shallow. "It just didn't have the information about numerous areas of [Claimant's] life. And I would have liked to have heard about it from his point of view, but it's not in there." Tr.117. Dr. Franklin stated that whatever conclusions Dr. Halote came to, he "couldn't quite find where [sic] it was dependant upon." Tr.117-118. Dr. Franklin further stated that Dr. Halote's report contained "a sort of fill-in-the-blanks mental status examination. It's very impersonal." Tr.119. Regarding Dr. Halote's subsequent reports, Dr. Franklin classified them as extremely shallow. These reports were each "just a form" on which Dr. Halote would check the appropriate box. Tr.149-155.

Dr. Halote did not get any information as to how Claimant was functioning on a day-to-day basis. Dr. Franklin testified that this information is relevant in rendering an opinion as to whether someone is depressed, as well as to how one reaches that diagnosis and what one thinks the prognosis is. Tr.124. Dr. Halote never discussed anywhere in his report, "how [Claimant] actually functioned." Tr.128. In looking at the portion discussing the tests that Dr. Halote administered, Dr. Franklin testified he could not tell what the test results were. Dr. Halote merely explained how the tests worked. Tr.120. Dr. Halote never stated how he arrived at his conclusions. Tr.122. In Dr. Franklin's opinion, Dr. Halote lifted sentences directly out of the raw test data, and included these in his conclusionary paragraph, assessing the results. Tr.125, EX-15, p.185-186.

Regarding the MMPI-II, F-scale result, Dr Franklin stated that anything above 65 is considered more than two standard deviations from the norm. At 65 or above, the result is suspicious. "And at 120, for sure, the test is completely skewed and it's invalid." He continues, "nobody really knows what these numbers mean, but it's usually referred to as the faking sick profile." Tr.122. According to Dr. Franklin, some people would dispute Dr. Halote's theory that this is invalid and should be ignored altogether. There are other numbers from the MMPI that could be used to determine if this really is a faking sick profile. Dr. Franklin mentioned the F minus K scale, as well as the Gough dissimulation scale. Dr. Franklin points out that Dr. Halote does not produce any of this information, and he did not do these analyses. He notes: "in this particular instance, that would be significant to receive that data." Tr.122-123.

Dr. Franklin testified that he does not agree with Dr. Halote's diagnosis. He stated that major depressive disorder is more than just a list of symptoms on the DSM-IV. He testified that he has discussed this with the people who created the book, and they warn that even if a person exhibits five out of the nine symptoms on the list, "unless you have some sense that there is serious dangerousness involved in the patient's behavior, then you don't have major depression." Tr.126-127. Dr. Franklin testified that he did not feel Claimant was going to kill herself. Tr.127. She was also leading a relatively normal life. Claimant was doing a lot of things Dr. Franklin felt that seriously depressed patients did not do. Tr.205. On those bases, he disagreed with the diagnosis of major depressive disorder. Tr.127, 205.

Dr. Franklin then discussed the diagnosis of post-traumatic stress disorder. He stated: "PTSD

is just thrown around now, everybody has PTSD." He explained that PTSD was never designed to be such a diagnosis. The 'trauma' is a life-threatening situation, or observing something that is life-threatening, such as witnessing someone getting killed. He stated it is "supposed to be something that is extraordinary." Tr.127. In Dr. Franklin's opinion, what happened to Claimant was an extraordinary event, but he did not think she was ever exposed to dying.[49] Tr.128. He opined the diagnosis of PTSD was somewhat exaggerated. Tr.128. Dr. Franklin testified that he did not remember reading any reference to flashbacks in Dr. Halote's reports. Dr. Franklin opined that flashbacks are a necessary prerequisite to PTSD as a diagnosis. Tr.132.

On cross-examination Dr. Franklin testified that Claimant may have had the *perception* that she almost died the night of February 8, 2000. Tr.173-174. He continued, "the issue is what happens to them afterwards? I'm not aware of people that go on for years believing that they were going to die in this kind of situation." Tr.175. When asked if the lapse in treatment may have affected Claimant adversely,[50] Dr. Franklin stated that, as a rule of thumb, early treatment is best to avoid developing serious psychological symptoms, but this rule does not necessarily apply to PTSD. It depends on what people are complaining about when they are first seen. "There's no rule of thumb on that." Tr.176.

When asked about Claimant's hospitalization in February, 2001, Dr. Franklin stated Claimant did not really mention the incident to him during the second evaluation. She had told him that she was hospitalized briefly, and was released. Tr.179. Dr. Halote's reports never mention the incident. Tr.155. Dr. Franklin was actually shocked when he learned that Claimant had been hospitalized for 10 days. Dr. Franklin testified that it would not change his diagnosis of Claimant. Tr.179-180. He opined that anti-psychotic drugs appeared to be the appropriate treatment for Claimant, but the hospital stay seemed "pretty long." Tr.180. Dr. Franklin testified that from what he could tell, such an episode had never happened before and it's never happened since. It did not change his diagnosis. Tr.181.

Other Testimony and Evidence:

Ms. Julie Vega:

Julie Vega testified on behalf of Claimant. She stated that they met at work in September, 1991. Tr.59. They became friends, and spent a lot of time together with their kids, camping, hiking, going to the beach. Tr.63. They lived together from January 1992, through March 1994. Tr.66. Since that time, they have lived so close to each other that "it's like we practically live together."

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[49]On cross-examination, Dr. Franklin clarified by stating that in comparison, he did not consider the injuries Claimant sustained that night to be anywhere near as serious as many other injuries he has seen in his career. Tr.198.

[50]There was a lapse of approximately six months between the accident and Claimant's first session with Dr. Halote's office. Tr.176.

Tr.65. They see each other every day, unless Ms. Vega has to work. Tr.65. On cross-examination, Ms. Vega testified that she knows Claimant very well. Tr.528. She stated: "I was her best friend, and was always there trying to, like, help her through that, and understand stuff."[51] Tr.548.

On cross-examination, Ms. Vega testified that Claimant has changed so much since the accident that they are no longer friends. Claimant ended the friendship three weeks before the trial, "just out of the blue." Ms. Vega was not sure why, but guessed it was "because of all of this." Tr.533. She testified she was "just here for old time's sakes [sic]." Tr.533.

Ms. Vega testified that until the accident, Claimant would accompany Ms. Vega when she jogged. Claimant would exercise in the center of the track while Ms. Vega ran laps. Tr.67-68. After the accident, Ms. Vega testified that all they did was "boring stuff, like go to Jack in the Box and grab a coffee or a chicken sandwich. And get on each other's nerves, because she – her personality and everything has changed." Tr.69. Ms. Vega testified that prior to the accident, Claimant was outgoing, really physical, basically very happy. She "never had any worries or anything." Claimant was not a person given to exaggeration. Tr.70. Ms. Vega stated that since then, Claimant is moody, she's always in pain, she always worries. She is always thinking about the past, when she was able to work, and be physical. Claimant is scared to go back to work, not sure if she can handle it, but she will go back if she has to. Tr.71-72.

When asked why Claimant is afraid to go back to work, Ms. Vega testified: "Because – yeah, I guess she keeps having those flashbacks from that container." Ms. Vega stated that she would sometimes stay overnight at Claimant's house, and Claimant would wake her up in the middle of the night with her flashbacks. Tr.72. Claimant would call Ms. Vega in the middle of the night, telling her that she is having flashbacks "of where she got injured." Tr.73. On cross-examination, Ms. Vega stated that Claimant is always talking about flashbacks. She tells Ms. Vega she can't forget the day of the accident, or how it felt to be thrown around "like being inside a washing machine." Claimant told Ms. Vega that she almost died because she couldn't breathe, and she can't forget. Tr.554.

Ms. Vega stated that Claimant told her about her nightmares. Claimant had a dream about her granddaughter's skull being cut in half in a jeep accident. Claimant kept saying she had killed her granddaughter. Ms. Vega testified that Claimant only had this dream once, but she kept dwelling on it. Tr.543. Claimant had dreams about three times, of evil people telling her to kill herself. Tr.544. Ms. Vega testified that these dreams occurred about a week before she was admitted to College Hospital. Tr.548. Claimant told Ms. Vega about her dream involving a baby and a dog. That Ms. Vega knows of, Claimant had that dream once. Tr.550.

On cross-examination, Ms. Vega testified that she drove Claimant to her doctors'

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[51]On cross-examination, Ms. Vega was asked if Claimant had a boyfriend. After pausing for a long period, she answered "No." She stated the reason for the long pause was that Claimant has a male friend, but Ms. Vega does not know if he is her "boyfriend." Tr.561.

appointments regularly. Claimant had told Ms. Vega that she was frustrated with the medical treatment she was having. Tr.534. Claimant had expressed her frustration with seeing a physician's assistant at Dr. Nagelberg's office, but only once. "She was kind of sad, because that day, I guess her doctor – her regular doctor had something else for – you know, I guess he had a surgery or something going on. That's why the assistant was there. . . So they rescheduled her so that she could actually see her physician." Tr.536. Claimant told Ms. Vega about the surgeries Dr. Nagelberg had recommended – low back, left knee, right knee and neck. Tr.537. Claimant had told Ms. Vega about her insurance problems. She told Ms. Vega that she had private insurance, and had asked her attorney if her private insurer would cover the surgeries. Tr.538-539. Ms. Vega testified that Claimant had never discussed her third-party lawsuit with her, "because I never wanted to listen to it, anyway." Tr.540.

Ms. Vega testified that Claimant called her from the emergency room at St. Mary's hospital in February 2001. Ms Vega testified that Claimant told her she was at a deposition and she just lost it. She was taken to the hospital in an ambulance. Ms. Vega testified that Claimant "looked weird. I mean, she was like something out of the Cuckoo's Nest." Tr.75. Ms. Vega described Claimant as all dazed, it wasn't her. She had a weird look on her face, she was mumbling weird stuff, and rocking back and forth. Tr.75-76. When asked whether she could determine what Claimant was mumbling, Ms. Vega testified: "Well, something about she was tired of all of this, she was tired of the pain, she's tired of having to go through all of this because of that accident she had. And she just wished she would be her normal self, normal life. And you know, everything normal for her." Tr.76.

Ms. Vega accompanied Claimant to College Hospital. Claimant was talking about wanting to either get well, or disappear. "She just didn't want to exist no more." Tr.78. Ms. Vega testified that Claimant was "not there." Explaining, Ms. Vega stated "Like I tell her, 'you're at another hospital,' you know 'where they're going to like watch you.' And she just – she wouldn't answer...it was like, 'Do you hear me?' And she just like nothing." Tr.78. Ms. Vega testified that this was the first time she had heard Claimant talk about wanting to disappear, not wanting to exist, ideas of suicide. "This is the first time because you know, it's like – you know, she just lost it that day." Tr.79. On cross-examination, Ms. Vega testified that Claimant has not mentioned wanting to kill herself in "probably a month and a half." Tr.562.

On cross-examination, Ms. Vega testified that Claimant never wears make-up. When they go out to dinner, she does not really try to make herself look presentable. Sometimes, Claimant forgets to comb her hair. "Sometime she didn't care what she looked like." Tr.555-556. Ms. Vega stated that Claimant's memory is bad. It has been bad for about four months. Ms. Vega opined that it is because she's all stressed out. Tr.557. Ms. Vega testified Claimant does not do household chores like vacuuming, cooking, cleaning and laundry. Her house is always dirty. Tr.558. Ms. Vega testified that Claimant runs errands once in a while, but only to pick up really light things. Claimant says driving hurts her, but she drives anyway, because she has to pick up her son. Ms. Vega stated that Claimant has come close to getting into accidents while driving because "she's not there," "she's all stressed out," and "she's not fast enough" on the brake. Tr.559-560. "There's been a couple of times when she almost ran over someone and she almost crashed into somebody." Tr.560.

Mr. Frank Weber:

Mr. Frank Weber, a private investigator for Weber and Associates, testified on behalf of Employer. Tr.1050. Mr. Weber has been a claims adjuster and investigator, specializing in Longshore Act claims for fifteen years. Tr.1051. Mr. Weber undertook surveillance of Claimant at the request of Mr. Ray Courtois, the claims manager for Commercial Insurance Services. Tr.1054. Mr. Weber testified that he began his surveillance of Claimant on December 9, 2000. On that day, no film of Claimant was obtained. Tr.1055. On December 14, 2000, Mr. Weber's colleague, Mr. Andre Winstanley conducted surveillance of Claimant. Again, no film was taken that day. Tr.1056.

Mr. Weber continued surveillance at six a.m. on January 12, 2001. At eleven a.m. Mr. Weber observed Claimant leave her apartment, get into her car, and drive to a Japanese restaurant. Tr.1060. She went into the restaurant, and returned with a grocery style bag. Claimant then drove to a high school, picked up a young man, and drove back to her apartment. Tr.1060-1061. When they arrived, the young man got out of the car and Claimant drove away.

At this point, Mr. Weber testified Claimant exhibited what, in the business, they refer to as "hinky." He explained that this term means Claimant began to exhibit patterns suggesting that she might be looking for surveillance. Tr.1061. Claimant drove down some side streets, instead of taking a main thoroughfare. She drove very slowly, and then went on to the main thoroughfare. Mr. Weber testified that he passed Claimant at this point, to avoid being spotted. Tr.1061. Mr. Weber drove past, turned around and came back and paralleled her. Again, Claimant was moving very slowly, cautiously. She stopped at an intersection and turned to her head fully to the left, leaning over the steering wheel, looking in his direction, where he had parked down a side street. Claimant then looked to her right, and drove through the intersection. Mr. Weber terminated surveillance at that time, as he didn't want to blow his cover. Tr.1062-1063. Mr. Weber testified that a total of four days were spent observing Claimant by both him and his colleague, Mr. Winstanley. Tr.1069.

On cross-examination. Mr. Weber explained that he did not film Claimant's "hinky" behavior, because it is very difficult to drive and video-tape at the same time. It would also have given him away, as he was sure Claimant was looking for him at the time. If she saw the camera, she would have known Mr. Weber was following. Tr.1077-1080.

Mr. John Andre Winstanley:

Mr. John Andre Winstanley, a private investigator with Weber and Associates, specializing in fraud and workers' compensation and employee-related injury, testified on behalf of Employer. Tr.1084. Mr. Winstanley undertook surveillance on Claimant on December 14, 2000, and January 19, 2001. Tr.1085.

At six a.m. on January 19, 2001, Mr. Winstanley did a search of the area surrounding Claimant's apartment, looking for her car. He did not see it, so he parked across a frontage road and then a busy street, facing towards Claimant's building complex, to observe. Tr.1086. Mr.

Winstanley testified that later that morning, Claimant arrived. She drove down the frontage road, driving extremely slowly, and looking all around at the vehicles parked on the frontage road. Claimant then turned and parked on a side street, where she sat in the car for a few minutes, looking around. Finally, she got out of the car and entered her building complex. Tr.1086-1087.

Mr. Winstanley opined that Claimant was looking for someone who was undertaking surveillance of her. He noted that the behavior was strange. She did not appear to be looking for a parking place. "She was looking specifically inside, rotating her head, looking in and down into vehicles[52] slowly as she drove into the area." Tr.1087.

Mr. Winstanley then testified that later, Claimant departed her complex. He followed Claimant to an adjacent shopping center, where she entered, driving very slowly like she was looking for someone. Mr. Winstanley stated he did not follow her into the parking lot. He pulled off to the side and watched. Claimant then exited the shopping center and drove on to the high school. She picked up the young man, and the two drove to Jack in the Box, in heavy traffic. At one point Mr. Winstanley had to pass Claimant, and it was then, he testified, he believed Claimant saw him. Tr.1088-1089. Mr. Winstanley immediately broke off surveillance, and knowing Claimant was heading towards home, he went back there and set up for further surveillance. Tr.1089.

Claimant then pulled up in her car, parked, and she and the young man sat in the car for an extended period of time. At this point, Claimant and the young man were turning their heads and looking all around. Mr. Winstanley testified that he tried to capture it on film, but couldn't. Tr.1089. Claimant and the young man then exited the car, looked straight over at Mr. Winstanley, at which time, Claimant made several gestures in his direction. First, Claimant shrugged her shoulders, "like okay, you got me." Tr.1089. Then Claimant gestured by hitting her right arm at the elbow with her left hand, and simultaneously raising her right fist at Mr. Winstanley. She then turned, and walked into her building, while waving him away. Tr.1090. See, EX-25. Mr. Winstanley immediately left the area, and surveillance on Claimant was halted. Tr.1090.

Mr. Raymond Courtois:

Mr. Raymond Courtois testified on behalf of Employer. Mr. Courtois is a claims manager for the carrier, Commercial Insurance Services. Tr.612. He testified that he was responsible for handling Claimant's claim, on behalf of Employer. Tr.614. Mr. Courtois testified that no one from Dr. Nagelberg's office contacted him to obtain authorization for Claimant's right knee surgery, which was performed on June 18, 2001. He further testified that he had initially authorized payment of disability benefits on February 9, 2000, and continued authorization through June 7, 2000. Tr.614-615. Mr. Courtois terminated benefits based on the opinions of Dr. Bhalla and Dr. London that Claimant was able to return to work. Tr.615. A notice of controversion was filed June 12, 2000. Tr.629. Mr.

[52]Mr. Winstanley testified that Claimant was driving an SUV-type vehicle, and so from her higher angle, Claimant had to rotate her head and look down into the vehicles as she passed. Tr.1088.

Courtois believed that the carrier and Employer were controverting all medical bills that arose after June 7, 2000. Tr.627.

ANALYSIS

I. Causation

As a result of the accident of February 8, 2000, Claimant alleges she sustained injuries to her head, neck, chest, left shoulder, contusions to the left knee, injury to her psyche, back, right knee and right shoulder. Employer stipulated to soft tissue injuries to Claimant's head, neck, chest, left shoulder and contusions to the left knee.[53] Thus, there is no need for the undersigned to discuss section 20(a) in regard to these injuries.

Those injuries stated by Employer as disputed at the outset of trial were psyche, back, right knee, and right shoulder. No evidence was offered of an injury to the right shoulder. Therefore, no benefits are in order, and Claimant's application for such must be denied. The injury in question was to Claimant's cervical spine, including pain and numbness radiating down her right arm. After a complete review of all of the evidence, the undersigned finds that the injuries in actual dispute are to the psyche, cervical spine, right knee and low back.[54] It is these injuries Claimant alleges are of an industrial nature, and therefore compensable under the Act. These are the issues the court will address.

An injury compensable under the Act must arise out of and in the course of employment. Section 20(a) of the Act provides that "in any proceeding for the enforcement of a claim for compensation under this Act it shall be presumed, in the absence of substantial evidence to the contrary (a) that the claim comes within the provisions of the Act." 33 U.S.C. §920(a). Thus, to invoke the 20(a) presumption, the claimant must establish a *prima facie* case of compensability by showing that she suffered some harm or pain, *Murphy v. SCA/Shayne Brothers*, 7 BRBS 309 (1977), *aff'd mem.*, 600 F.2d 280 (D.C. Cir. 1979), and that working conditions existed or an accident occurred that could have caused the harm or pain, *Kelaita v. Triple A Machine Shop*, 13 BRBS 326 (1981). The presumption cannot be invoked if a claimant shows only that she suffers from some type of impairment. *U.S. Industries/ Federal Sheet Metal, Inc. v. Director, OWCP*, 455 U.S. 608, 615, 102 S.Ct. 1312, 1317 (1982) ("The mere existence of a physical impairment is plainly insufficient to shift the burden of proof to the employer.") However, a claimant is entitled to invoke the presumption if she presents at least "*some* evidence tending to establish" both prerequisites and is not required to prove such prerequisites by a preponderance of the evidence. *Brown v.*

[53]See footnote 2, *supra*.

[54]Employer agrees Claimant suffered from soft tissue injuries to her neck, ("neck strain") but not to injury to her cervical spine.

I.T.T./Continental Baking Co., 921 F.2d 289, 296 n.6 (D.C. Cir. 1990).

Claimant has put forth sufficient evidence to establish a *prima facie* case of compensability. It is uncontroverted that Claimant was injured in an industrial accident on the night of February 8, 2000. Claimant testified that the injuries to her right knee, cervical spine, low back and psyche developed after this incident. Dr. Nagelberg testified that Claimant's physical injuries were of an industrial nature. Dr. Halote testified that Claimant's psychological condition stems from the trauma of that industrial accident. This evidence is clearly "some evidence tending to establish" that Claimant suffered some harm or pain, and that an accident occurred that could have caused the harm or pain. I therefore find that Claimant has presented evidence sufficient to invoke the section 20(a) presumption.

Once the Section 20(a) presumption is invoked, the burden shifts to the employer. To rebut the presumption, the employer must present substantial evidence that the injury was not caused by the claimant's employment. *Dower v. General Dynamics Corp.*, 14 BRBS 324 (1981). If the presumption is rebutted, it falls out of the case, and the administrative law judge must weigh all of the evidence and resolve the issue based on the record as a whole. *Hislop v. Marine Terminals Corp.*, 14 BRBS 927 (1982). The ultimate burden of proof then rests on the claimant under the Supreme Court's decision in *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 114 S.Ct. 2251 (1994). See also *Holmes v. Universal Maritime Services Corp.*, 29 BRBS 18, 21 (1995).

Employer is able to carry its burden to rebut Claimant's *prima facie* case. Dr. London testified that Claimant's neck and knee injuries are both degenerative in nature, and therefore not caused or aggravated by the industrial accident. Dr. London further testified that Claimant could not have sustained a meniscal tear to her right knee in the incident, as it occurred. Dr. Farran testified that Claimant's injuries are degenerative in nature, and could not have been the result of the February 8, 2000, incident. He also testified that a knee injury such as Claimant suffered is either caused by degeneration, or by a twisting, weight-bearing blow to the knee. If it was the latter, Claimant did not express a complaint about her right knee until March 24, 2000. It could not have occurred in the February 8, 2000, incident without Claimant being immediately aware of such an injury. Dr. Rothman testified that Claimant's radicular complaints have no physiological basis. He testified that Claimant's cervical condition is degenerative. He further testified that Claimant's knee injury is degenerative in nature, and could not have been the result of the February 8, 2000, incident. Drs. London and Farran testified that Claimant's low back condition is minor, and degenerative in nature. It could not have been aggravated by, nor was the result of the February 8, 2000 incident. Dr. Franklin testified that Claimant does not suffer from post-traumatic stress disorder, nor from major depression, and is, in his opinion, psychologically capable of working. Based on the foregoing, the undersigned finds that Employer has rebutted Claimant's *prima facie* case by substantial evidence.

The next step in the analysis is to weigh the evidence as a whole. Claimant has the burden of proof to show by a preponderance of the evidence that her injuries were caused by the industrial accident she suffered on February 8, 2000. The undersigned finds that she has not carried that burden.

A. Physical Injuries to Cervical Spine, Right Knee and Low Back

Claimant's testimony, as explained previously, carries little weight. Claimant's symptoms grew exponentially from the time her doctor declared her permanent and stationary on March 25, 2000, to as soon as her first appointment with Dr. Nagelberg on March 28, 2000, and continued to change up to, and during the trial. Her subjective complaints have little, if any correlation to any objective findings. She has been wholly inconsistent in her reporting of symptoms over the past year and a half. Claimant insisted that her English was not very good, and yet she was able to testify without the aid of an interpreter. She was able to communicate with all of her doctors without the aid of an interpreter. None of Claimant's physicians testified that there was any communication problem due to a language barrier. Claimant gave conflicting and inconsistent testimony throughout the proceedings.[55]

The undersigned has disregarded Claimant's testimony as proof of her injuries. What is left then, is the testimony of the parties' medical experts. Because I give more credence to Employer's experts on the issue of Claimant's physical injuries, than I do her treating physicians, I find that the evidence shows that the physical injuries in dispute were not caused by the February 8, 2000, incident, but are degenerative in nature. Claimant is therefore not entitled to medical expenses for their treatment, nor is she entitled to compensation for the specific injuries she alleges to her cervical spine and right knee.

When considering medical evidence concerning a worker's injury, a treating physician's opinion is entitled to "special weight." *Amos v. Director, OWCP,* 153 F.3d 1051 (9th Cir. 1998). However, a treating doctor's opinion is not necessarily conclusive regarding a claimant's physical condition or the extent of her disability. See *Magallanes v. Bowen*, 881 F.2d 747, 751 (9th Cir. 1989); *Amos,* 153 F.3d at 1054, ("special weight" standard limited to treating doctor's opinion regarding treatment). Moreover, the court may reject the opinion of a treating physician which conflicts with the opinion of an examining physician, if the decision sets forth "specific, legitimate reasons for doing so that are based on substantial evidence in the record." *Magallanes,* 881 F.2d at 751.

The Court finds Dr. Nagelberg's opinion of Claimant's injuries unreliable, as he relied heavily on Claimant's unsupported subjective representations of her symptoms, which are not substantiated by the objective findings. Dr. Nagelberg also failed to review any of the medical reports pertaining to the accident prior to making his diagnosis. Furthermore, the Court notes several deficiencies in Dr. Nagelberg's reports. Dr. Nagelberg operated under a misunderstanding of the mechanism of injury, his reports are missing pertinent information, and he was unaware that his patient was continuing to undergo treatment he had suspended. In contrast, Dr. London, Dr. Farran, and Dr. Rothman's conclusions are based on all of Claimant's medical records, the MRI studies, CT scan, as well as EMG and nerve conduction studies. They are detailed and thorough in their analysis of Claimant's condition. Therefore, the undersigned finds these opinions well-reasoned and more

[55]See, Claimant's Testimony and Background, supra, p.3-6.

persuasive than Dr. Nagelberg's.

Dr. Nagelberg's reliance on Claimant's recitation of symptoms is misplaced, as the Court does not consider Claimant to be a credible witness. Dr. Nagelberg's examination results all rely on Claimant's subjective responses. He reports Claimant's motor functions intact in all muscle groups, sensation intact, reflexes were 2+ bilaterally, with no pathology, and negative straight leg raising tests. He reports moderate tenderness all over, and limited range of motion. X-rays revealed no abnormalities. Dr. Nagelberg concluded that Claimant was suffering from both cervical and lumbar radiculopathy and internal derangement of both knees. He ordered MRI studies to substantiate his diagnoses. CX-24, p.38-40.[56] Dr. Nagelberg did not document any objective evidence of Claimant's complaints. Dr. Nagelberg admitted that he cannot explain Claimant's radicular complaints, based on the results of the diagnostic studies. He testified that these complaints are most likely related to Claimant's psychological condition. Tr.255. Still, he is determined to perform painful, invasive surgery. Even in the face of negative nerve conduction studies, negative EMG results, and MRI studies that reveal a minimal disc abnormality, Dr. Nagelberg insists that based on the MRI studies, Claimant will benefit from neck surgery because she is still complaining of pain. Tr.257.

Dr. Nagelberg did not review Claimant's prior medical records, in which Claimant's complaints were limited to her left leg, chest, low back and neck. He did not review the examination and conclusions of Dr. Bhalla, reported just three days before he examined Claimant himself, in which Claimant's complaints were substantially fewer that the total body pain she described to Dr. Nagelberg. Tr.243-244. The undersigned finds it curious that Claimant's injuries could change so exponentially, and not raise any red flags for a treating physician, had he read the reports.

Dr. Nagelberg's reports are not very thorough, nor are they accurate. In Dr. Nagelberg's first report, dated March 29, 2000, he incorrectly reports that the mechanism of Claimant's injury resulted from an accident Claimant was involved in while driving a forklift. He states Claimant was injured when "a box being loaded onto the forks of the forklift fell causing the forklift to bounce three times." EX-18, p.476. Throughout Claimant's treatment, this error went uncorrected. Dr. Nagelberg never asked Claimant what her daily activities were, or what she was able to do on a day-to-day basis, given her condition. Tr.319. Dr. Nagelberg insisted that he examined both of Claimant's knees, and yet his first report of March 29, 2000, is lacking in any discussion of the right knee itself. The examination heading is 'Left Knee' and his report is written in the singular, yet on cross-examination, Dr. Nagelberg insisted that he was referring to both knees throughout. Tr.282-284. Dr. Nagelberg testified that Claimant had complained of right knee pain on July 13, 2000, as well, but he did not include it in his report. Nor did Dr. Nagelberg include any findings regarding the right knee on August 25, 2000. In addition, he did not include Claimant's complaints of pain radiating into her left

[56]The first results of the cervical spine studies indicated that Claimant suffered from a mild, or 3 millimeter disc bulge at C-4/5, and a 4 millimeter disc bulge at C-5/6. The second study showed that the disc bulge at C-5/6 had shrunk to 1 millimeter. Tr.233. Dr. Nagelberg testified that this mild effacement of the spinal cord *may* cause Claimant's pain, but not all of Claimant's complaints are explainable by this abnormality. Tr.231-232.

hand. Tr.335.

On August 29, 2000, Dr. Nagelberg decided that Claimant was not benefitting from the physical therapy and Claimant was instructed to stop going. Yet Claimant continued to go three to four times a week, until January 29, 2001, without intervention by Dr. Nagelberg or his staff. Dr. Nagelberg admitted that this was inappropriate. Tr.295-296. Dr. Nagelberg did not actually regularly treat Claimant himself, but assigned her case to his Physician's Assistant, Mr. Rassmussen. Dr. Nagelberg testified he only actually examined, or spoke to Claimant on three out of eight visits.[57] Tr. 307-308. Many, if not most of Dr. Nagelberg's conclusions were based on what was reported to him by Mr. Rassmussen, not his own observations of Claimant. Tr.285-286.

Dr. Nagelberg testified that "[i]t soon became obvious to me that in addition to the orthopedic complaints she had, there was a psychological component to her pain," Tr.222. Yet Claimant's first visit to Dr. Halote did not occur until August 25, 2000, five months after Dr. Nagelberg began treating her. EX-15, p.181. It was not until his testimony at trial that Dr. Nagelberg even mentioned any psychological element to Claimant's radicular complaints.

Dr. Nagelberg continued to assert his belief that Claimant is a good candidate for neck surgery. His reasoning was that Claimant has proven to him that she can benefit from surgery, and that she is not malingering. "She proved that to me with her [right] knee." Tr.265-266. The flaw in this reasoning is that there is no dispute that Claimant suffered from a meniscal tear in her right knee. Claimant required surgery on the right knee. Both Claimant's and Employer's experts are in agreement. The studies done on Claimant's neck, however, do not show objectively, that Claimant's pain would be relieved by neck surgery. On the contrary, all are in agreement, including Dr. Nagelberg, that Claimant's symptoms cannot be explained by the abnormalities on the MRI studies. There is no objective evidence that Claimant's radicular complaints would be relieved by neck surgery.

What is in dispute regarding the right knee is whether the injury is degenerative, or a result of the February 8, 2000, accident. Dr. Nagelberg opined the injury was clearly the result of a traumatic event. He based this opinion on his recollection of Claimant's subjective complaints of pain following the accident, even though Claimant never complained of right knee pain until she was examined by Dr. Bhalla on March 24, 2000. When cross-examined on his theory of Claimant's injury, Dr. Nagelberg changed his reasoning to include some sort of twisting injury to the knee, but not necessarily a weight-bearing injury, plus some degree of favoring of the right side, due to Claimant's pain in her left knee, although Dr. Nagelberg's reports did not mention this complaint until December 13, 2000. Tr.316-319. Dr. Nagelberg's own surgical report stated that the tear was a "degenerative horizontal cleavage tear." CX-71, p.628.

Regarding the alleged injury to the low back, Dr. Nagelberg's examinations of Claimant

[57]A review of Dr. Nagelberg's medical records indicate that Claimant was examined by Mr. Rassmussen on five out of ten visits. CX-24 to CX-35.

revealed a negative straight leg raising bilaterally, motor "examination" intact in all muscle groups, and sensation intact to both pinprick and light touch. Claimant suffered from moderate posterior tenderness. CX-24, p.39. X-rays of the lumbar spine showed no significant abnormalities, and Dr. Nagelberg agreed that the MRI of Claimant's lumbar spine was normal. Tr.233. Claimant had a minor degree of disc degeneration at L/5-S/1. Tr.291. Dr. Nagelberg had noted in a report dated July 27, 2000, that he was considering lumbar discography if Claimant did not respond to non-operative care. CX-27, p.48. He was of the opinion that Claimant's temporary total disability was related mostly to her cervical spine, and low back pain. Tr.229. Yet Dr. Nagelberg testified that he had no intention of performing low back surgery, and did not give any opinion as to further treatment for Claimant's low back.

In contrast, the opinions of Dr. London, Dr. Farran and Dr. Rothman are all persuasive. None of these experts relied on Claimant's subjective complaints in reaching their diagnosis. All three experts reviewed Claimant's entire medical history pertaining to the February 8, 2000, injury before rendering an opinion. All three experts were of the opinion that Claimant suffers from a degenerative disc condition in her cervical spine. Dr. Farran testified that the presence of osteophytes on the MRI suggests degenerative changes. Tr.787-788. He further testified that although a trauma may aggravate a degenerative condition, the injury that occurred on February 8, 2000, was not serious enough to do so. Tr.786. Dr. Rothman testified that Claimant suffered from a mild degenerative disc bulge, with slight possibility of nerve root compression at C-4/5, due to a degenerative bony ridge. Tr.366-367. He opined that the accident of February 8, 2000, could not possibly have caused anything visible on the MRI studies. Tr.392-393.

Employer's experts were in agreement that Claimant's radicular complaints would not be resolved by surgery to her cervical spine. Each expert explained to the Court that the only areas in Claimant's neck that may be irritating a nerve would be at the C-4/5 or C-5/6 level. This would cause irritation in the C-5 or C-6 nerves. Dr. London explained that the C-5 nerve goes to the shoulder and outer aspect of the upper arm. Tr.439. Dr. Rothman explained that the C-6 nerve root innervates the thumb and index finger, the C-7 goes to the middle finger and inner portion of the fourth finger. Dr. Farran stated that in order to affect all the fingers Claimant complained of, there would have to be disc abnormalities at C-6/7, and C-7/8. Tr.796. Claimant's complaints of pain in select fingers of her hand do not correlate with any abnormalities viewed on the MRI studies. Tr.367-368. In reviewing all of the objective testing conducted on Claimant, not one expert, including Dr. Nagelberg, could find a physiological basis for Claimant's radicular complaints. There was no evidence that fusion of the C-4/5, as Dr. Nagelberg intends to perform, will cure Claimant's radicular pain.

Both Dr. London and Dr. Rothman were of the opinion that the meniscal tear in Claimant's right knee was entirely the result of a degenerative condition. This was evident in the surgical photographs of Claimant's right knee, as well as the surgical report of Dr. Nagelberg. Tr.456. Drs. London and Rothman went into great detail as to how such a traumatic injury could occur. Their explanations of a hard blow to the knee, with weight-bearing and twisting, all occurring simultaneously, are more convincing than Dr. Nagelberg's suggestion that this injury occurred because of favoring the right knee over the left, following the accident. Dr. London was asked if Dr. Nagelberg's explanation was plausible. He opined that Claimant's activity level after the accident

would have been reduced, lessening any force or weight applied to the right knee, even if she was overcompensating for her left knee pain. Tr.605-608. Dr. London testified that if Claimant had suffered a meniscal tear in her right knee on February 8, 2000, she would have been complaining of pain immediately, and there would have been physical findings of an injury, such as swelling and limping. Tr.451-454.

At the time Dr. Farran conducted his physical examination, Claimant showed no objective signs of pain. She complained of total body pain, yet she walked without any impairment of her gait. She did not grimace, she had no demeanor of significant distress. Tr.764. Almost all tests were normal, with the exception of Claimant's motor system, which revealed a give-way ratcheting, indicating Claimant did not suffer from true weakness in her muscles, she was not giving her full effort. Tr.766. Dr. London, upon examination, stated that Claimant's test results were "notable for their normalcy." EX-10, p.162. Neither doctor found any atrophy of the muscles, loss of muscle bulk, which, Dr. Farran opined, one would expect if a person has the significant type of weakness Claimant was complaining of. Tr.782. Straight leg raising tests conducted by Dr. London were normal. The same tests conducted by Dr. Farran were conflicting. Claimant suffered from pain when the test was conducted lying down, but she experienced no pain when the same test was conducted sitting up.

Drs. London, Rothman and Farran were all of the opinion that the condition of Claimant's back was degenerative in nature. Dr. London's examinations revealed no pathological features in Claimant's gait, normal reflexes, negative straight leg raising bilaterally, and a tenderness that was not well localized. He testified that Claimant suffered from a generalized tenderness over the iliac crest, extending all the way around to the front of the pelvis, as well as all the way from the neck, down the thoracic spine. Tr.415-416. Dr. London reviewed the MRI of Claimant's lumbar spine. There was no evidence of nerve root impingement, and normal disc spacing. Claimant had a one millimeter disc bulge at L/5-S/1, which was degenerative in nature. Based on the normal MRI, the negative EMG and nerve conduction studies, and normal neurological studies of the lower extremities, Dr. London opined that it would be below the standard of practice in the community to operate on Claimant's lower back. Tr.441-442. These minor degenerative abnormalities would not affect Claimant's ability to return to work without restriction. Tr.427-428.

Dr. Rothman was in full agreement with Dr. Nagelberg's radiologist, Dr. Crues, that Claimant had a mild degenerative abnormality in the lumbar spine, with no evidence of any pressure on any of the nerve roots. He noted a darkening of the disc, signifying dehydration, which is an age-related degenerative change. Tr.362-363. Dr. Farran's examination of Claimant's lower back revealed an average limitation in flexion for someone of Claimant's age, although Claimant's range of motion was significantly limited. She had a mild degree of paraspinus muscle tenderness which Dr. Farran found disproportionate to her range of motion limitation. Tr.764-765. Straight leg raising tests performed both sitting and lying down were inconsistent. Dr. Farran opined that this may be a sign of malingering. Tr.784. Her neurological testing was normal, as well as EMG and nerve conduction studies. TR.767-768. Dr. Farran diagnosed Claimant as having suffered a sprain/strain of her lower back from the February 8, 2000, incident. He opined that given that all testing was normal, regardless

of Claimant's subjective complaints, she had reached maximum medical improvement, and was capable of returning to work without restriction as of May 16, 2000. Tr.771.

In sum, there was little, if any objective evidence to support Claimant's subjective complaints. The diagnostic testing performed at the behest of Dr. Nagelberg was all normal. Curiously, Dr. Nagelberg changed his diagnosis at trial to include psychogenic overlay, thus explaining this deficiency in objective evidence. Still, Dr. Nagelberg insists Claimant requires painful discography and surgery. The undersigned agrees, however, with Dr. Rothman, Dr. London and Dr. Farran. Conducting surgery on a patient who's symptoms are psychogenic, and not physiological, seems "destined for failure." Tr.384. Further, the objective evidence, the MRI studies and reports, x-rays, CT scan, photographs, and surgical report all show a degenerative condition in the right knee, cervical spine and low back. Weighing the evidence as a whole, I find that these injuries are not of an industrial nature, and are not compensable under the Act.

B. Psychological Injury

Claimant has shown that she suffers from a mood disorder stemming from her non-industrial orthopedic condition, but has not shown she suffers from post-traumatic stress disorder, nor from a major depressive disorder. The undersigned cannot credit Claimant's treating psychologist, Dr. Halote, and instead credits the opinion of Employer's expert, Dr. Franklin. Dr. Halote based his diagnosis solely on Claimant's subjective complaints. He did not review Claimant's prior medical records. The Court also notes many deficiencies in Dr. Halote's reports. Furthermore, Dr. Halote did not actually treat Claimant. In fact, he spent less time with Claimant than Dr. Franklin. In contrast, Dr. Franklin's diagnosis was based on his objective observations of Claimant. Dr. Franklin reviewed all of Claimant's prior records, both medical and psychological. Dr. Franklin's reports are well-reasoned and more persuasive than Dr. Halote's. The undersigned therefore gives more credence to the opinion of Dr. Franklin than Dr. Halote, and finds that Claimant suffers from a mood disorder due to her orthopedic condition. As Claimant's underlying orthopedic condition does not stem from the industrial accident at issue, Claimant is not entitled to compensation for her mood disorder under the Act.

In his only narrative report, dated September 13, 2000, Dr. Halote gave no objective foundation for his opinion that Claimant suffers from a major depressive disorder and post-traumatic stress disorder. His diagnosis was based on Claimant's unsubstantiated subjective complaints. Dr. Halote testified that Claimant seemed to be in pain. He did not, however, report any objective signs of this. Claimant told Dr. Halote she was depressed and anxious. She complained of difficulty sleeping. She was experiencing nightmares. Claimant told Dr. Halote she had suicidal ideation. Dr. Halote took Claimant at her word. He did not find merit in the theory that depressed people are more likely to neglect their outward appearance. He stated that whether a patient is wearing make-up, hair brushed, clothes tidy, may have no bearing at all on their mental state. EX-26, p.989. Dr. Halote testified that in the field of psychology, there are rarely, if ever, any objective findings. He stated as an example, that unless a patient tells him she is hallucinating, there is no way to know. EX-26,

p.1011. Dr. Halote examined a clean, neatly groomed and casually dressed woman who was cooperative, yet passive. Her body posture was slumped and she looked uncomfortable. She cried. Dr. Halote concluded that Claimant was severely depressed and in pain. Dr. Halote's objective observations that Claimant was neatly dressed, cooperative, had no problems with perception, had normal thinking and intellectual functioning, and a normal stream of thought, do not correlate with his conclusions, nor with Claimant's subjective complaints. EX-15, p.182-183. The undersigned does not credit Claimant's testimony, and cannot therefore credit Dr. Halote's conclusions that Claimant was depressed, suicidal and suffering from insomnia.

There are problems with Dr. Halote's examination of Claimant. Dr. Halote did not take any personal history from Claimant. He neglected to inquire into Claimant's family life, her personal situation, background, nor did he ask Claimant how she was functioning on a daily basis. He was not aware if Claimant was able to drive herself to appointments, do housework, shop, visit with friends. Dr. Halote stated that this may or may not be important information, it would depend on the degree. EX-26, p.987-988. As Dr. Halote did not inquire into this area, he is unable to evaluate its importance or lack thereof. Dr. Halote explained that he thought he was examining Claimant for a state workers' compensation claim, not a federal claim, and therefore, this information was not required. EX–26, p.948-953. Dr. Halote opined that this was information needed only at the apportionment stage, not the treatment stage. EX-26, p.951-953. This explanation is weak, at best. Without a full understanding of Claimant's situation, without inquiring into all areas of her life, a complete and accurate diagnosis would be problematic.

Further, Dr. Halote did not review any of Claimants' prior medical history. EX-15, p.181-187. He did not inquire of Dr. Nagelberg as to Claimant's orthopedic status. When questioned on this point, Dr. Halote responded that anything he needed to know he could find out from the patient. EX-26, p.923. Dr. Halote testified that he merely took a minimal amount of physiological information from Claimant "as to how her physical complaints might be affecting her psychological[ly]." EX-26, p.947. If a patient were malingering, or just unreliable, Dr. Halote would not obtain accurate information from the patient herself. Dr. Halote would then be mis-informed about his patient's physical status. Why not confer with the treating physician, or read the treating physician's reports, and thus obtain accurate medical information?

Dr. Halote's report is superficial and conclusory. The section headed Mental Status Examination is a "fill in the blank" format. EX-15, p.183. Dr. Halote conducted psychological testing on Claimant. His report, however, fails to disclose the individual test results. Dr. Halote merely explains which tests he administered, and what conclusions he reached from the results. The only test results Dr. Halote did give in his report, the MMPI-2, he ignored, because the test was invalid.[58] Dr. Halote admitted that this was not proper procedure. EX-26, p.892. He admitted that no one reading his report could tell how he reached his conclusion. EX-26, p.974.

Dr. Halote failed to include other important information in his report. His reports are devoid

[58]See Dr. Halote's explanation, p.30, *supra*.

of any mention of flashbacks, but the undersigned is to believe Claimant suffered from flashbacks based on Dr. Halote's recollection of the interview. EX-26, p.985. This is a critical issue, as Dr. Halote's diagnosis of post-traumatic stress disorder was based on Claimant presenting "five out of nine of the DSM-IV criteria," as well as her complaints of flashbacks, and fearfulness of the injury.[59] Dr. Halote did not specify what the five out of nine criteria were that Claimant had met, he only specified that her flashbacks and fearfulness were bases for his diagnosis. EX-26, p.894. If flashbacks were so critical to his diagnosis, one would expect Dr. Halote to record this finding somewhere in his report. Interestingly, when asked why she could not work as a UTR driver anymore, Claimant responded that she couldn't, not out of fear, or flashbacks of the accident, but because there are holes in the yard that she would have to drive over, which she feared would damage her neck and back. Tr.1147. Claimant herself, seems to contradict Dr. Halote's diagnosis.

Dr. Halote testified at length that he believes Claimant is suicidal. He based his diagnosis of major depressive disorder partially on this opinion. He felt Claimant should not be driving a truck if she is suicidal. Ex-26, p.911. Yet in his report, Dr. Halote stated that Claimant disclosed suicidal ideation, "but showed no intent or plan to carry it out." EX-26, 891. It is difficult for the undersigned to reconcile this contradiction.

Dr. Halote did not actually treat Claimant. Dr. Halote assigned Claimant's case to others for her actual treatment. Dr. Halote was given reports as to Claimant's progress. He did not spend any more than one and a half hours with Claimant over the course of her treatment. Dr. Halote testified that he met with Claimant for fifteen minutes in February 2001 to refresh himself on how Claimant was doing, "to sort of make contact with her," six months after Claimant began treatment. EX-26, p.896. Within this fifteen minutes, Dr. Halote was able to conclude that Claimant was still depressed, anxious, still in pain, and still in need of weekly counseling. EX-26, p.896. Dr. Halote testified that he met with Claimant again, two weeks before his deposition so he could refresh his memory as to who Claimant was. EX-26, p.897. Dr. Halote did not know what Claimant's job entailed. He was under the impression that Claimant drove an 18-wheeler on the freeway. Ex-26, p.911. Yet Dr. Halote insisted that he remembered Claimant and the first interview. Dr. Halote insisted he was capable of making a diagnosis based on his independent recollection of Claimant. EX-26, p.985.

In contrast, Dr. Franklin's opinion is more persuasive, and based on Claimant's complete medical and personal history, as well as his objective observations, giving it more weight than Dr. Halote's. Dr. Franklin reviewed all of Claimant's medical records prior to the interview. He had the benefit of a full understanding of the metamorphosis of Claimant's symptoms since the accident. He was familiar with Claimant's treatment history, and its lack of success in controlling her pain.

Dr. Franklin was very thorough in his interview with Claimant. He took a complete history, including Claimant's past, her family situation, social life, and especially how she functions on a day-

[59]Dr. Franklin testified that according to the DSM-IV, flashbacks are necessary for a diagnosis of PTSD. Tr.132.

to-day basis. Dr. Franklin knew Claimant could drive, she could shop, cook, wash dishes and make beds. He was aware that Claimant had two close friends that she spoke with on a regular basis. He reasoned that this information is helpful to him as it gives him an idea of how the patient spends her time. It is relevant in diagnosing depression. Tr.124. He noted that Claimant was engaging in normal daily activity. Tr.102-103. She was leading a relatively normal life. Tr.205.

Dr. Franklin noted a wide range of objective findings. He observed that Claimant was well-groomed, she even plucked her eyebrows. In contrast to Dr. Halote, Dr. Franklin thought these observations very important, as they show how a person is functioning. Claimant was not withdrawn, she showed an interest in her appearance and there was no deterioration in her hygiene. Tr.91-94. Dr. Franklin noted that Claimant did not appear to be in any acute distress. She did not walk with an altered gait. She did not grimace or moan, as if in pain. Tr.92. He noted Claimant sat in a very soft chair that is usually spurned by people with back problems. She had no difficulty sitting through the entire interview, and had no difficulty getting out of the chair when it concluded. Tr.92. Dr. Franklin observed that Claimant did not yawn or sigh, and appeared to have no bags or circles under her eyes. Dr. Franklin further noted that Dr. Halote was not treating Claimant for insomnia, so he did not believe it to be a serious problem. Tr.214. All of these careful observations lead one to believe that Claimant was not in acute pain, nor was she suffering from insomnia, as she claimed to be.

Dr. Franklin discussed Claimant's dreams with her, something Dr. Halote did not delve into. He opined that they were so bizarre he tended to discount them. To him, this was a sign of Claimant's histrionic tendencies. Tr.217. He testified Claimant did not report any flashbacks to him, a symptom necessary to a diagnosis of PTSD. Tr.132. They discussed her thoughts of suicide in some detail. He testified that unless there is a serious dangerousness to a patient's behavior, they do not have major depression. Tr.127. Claimant told Dr. Franklin that she had thought about it in the past, but no longer had any suicidal intent. Tr.103. From this, Dr. Franklin logically concluded that Claimant was not a suicide risk. Claimant was not suffering from major depression. Tr.126-127.

Dr. Franklin diagnosed Claimant as suffering from a mood disorder due to her orthopedic condition. He hypothesized that she may be malingering and may have histrionic personality traits, but did not think this to any degree of medical certainty. He felt that the continued treatment of Claimant was detrimental to her. She would only continue to believe there was something wrong with her, when in fact, she was healthy. Tr.181-182, 188-189. He did admit he thought the psychotropic drugs were benefitting Claimant's mental well-being. Tr.148.

The undersigned accepts Dr. Franklin's diagnosis and agrees with him that Claimant could benefit from continued medication. However, as the undersigned has already concluded that Claimant does not suffer from an orthopedic condition that is industrial in nature, Claimant's psychiatric condition does not stem from any compensable injury. Claimant is therefore not entitled to benefits

In conclusion, Claimant has failed to establish a causal link between her right knee, cervical spine and low back injuries and the industrial accident that occurred on February 8, 2000. Claimant is therefore not entitled to compensation for these injuries, nor are her treating physicians entitled to payment from Employer, for their respective services. Furthermore, Claimant has failed to establish that she suffered a psychiatric injury which occurred as a result of the industrial accident. Claimant suffers from a mood disorder. That disorder however, is not industrial in nature, and is not the financial responsibility of Employer. She is therefore not entitled to compensation for this injury, nor is her physician entitled to payment from Employer under the Act.

II. Extent of Temporary Total Disability

The burden of proving the nature and extent of disability rests with the claimant. *Trask v. Lockheed Shipbuilding Constr. Co.*, 17 BRBS 56, 58 (1980). Disability is generally addressed in terms of its nature (permanent or temporary) and its extent (partial or total). The Act defines disability as an "incapacity to earn the wages which the employee was receiving at the time of injury in the same or any other employment." 33 U.S.C. § 902(10). Therefore, the claimant must demonstrate an economic loss in conjunction with a physical or psychological impairment in order to receive a disability award. *Sproull v. Stevedoring Service of America*, 25 BRBS 100, 110 (1991). Thus, a disability requires a causal connection between a worker's physical injury and her inability to obtain work. If the claimant shows she cannot return to her prior job, it is the employer's burden to show that suitable alternate employment exists which she can perform. Under this standard, a claimant may be found to have sustained no loss, a total loss or a partial loss of her wage-earning capacity.

Claimant argues she remains temporarily totally disabled after the February 8, 2000, accident. Dr. Nagelberg and Dr. Halote continue to treat Claimant and do not feel she has yet reached the point of maximum medical improvement.

As the Court finds Claimant's injuries to her cervical spine, right knee and low back were not caused by the industrial accident, it need not discuss the extent of any disability related to those injuries. As to the compensable injuries Claimant suffered due to the industrial injury of February 8, 2000 – to Claimant's head, neck, chest, left shoulder and left knee – they were to soft tissue only and were fully healed as of March 24, 2000. For the reasons discussed in the analysis above, I find Drs. Burns, Bhalla, London, Farran, and Rothman more reliable than Dr. Nagelman. I therefore accept Drs. Bhalla's, London's, Farran's and Rothman's opinion that Claimant's industrial injuries had fully healed as of March 24, 2000, and she could return to her longshore position with no limitations as of that date. Both Dr. Burns and Dr. Bhalla found Claimant's soft tissue injuries fully healed in March 2000. Dr. London, Dr. Farran, and Dr. Rothman testified that soft-tissue injuries will heal, on their own, within a maximum period of ten to twelve weeks. The undersigned thus finds that Claimant's physical injuries stemming from the accident were fully healed as of Claimant's final visit with Dr. Bhalla, on March 24, 2000, based on the opinions of Dr. London, Dr. Farran, and Dr. Rothman. Claimant reached maximum medical improvement and was able to return to her prior longshore position with no limitations as of Dr. Bhalla's release to work, dated March 25, 2000.

In regards to Claimant's psychological injury, based on its previous reasoning, the Court accepts the opinion of Dr. Franklin over that of Dr. Halote. Claimant's psychological injury stems from her orthopedic condition which is not industrial in nature. Although the Court need not discuss the extent of Claimant's disability as it relates to her psychological injury, it finds that such injury – mood disorder related to orthopedic condition – while not causally related to the industrial accident in question, imposes no limitations on Claimant's ability to return to her prior position as a longshoreperson.

III. Section 7 Benefits

Section 7(a) of the Act, 33 U.S.C. §.907(a), states that "[t]he employer shall furnish such medical, surgical, and other attendance or treatment . . . for such period as the nature of the injury or the process of recovery may require."

Section 7 requires the employer to furnish the injured employee with medical care that is reasonable and necessary. *Pernell v. Capitol Hill Masonry*, 11 BRBS 532, 539 (1979). The claimant has the burden of proof to show that the medical services are related to the compensable injury, *Pardee v. Army & Air Force Exchange Service*, 13 BRBS 1130 (1981), and are reasonable and necessary. The claimant is not aided by the section 20(a) presumption, which applies solely to the issue of compensability. *Schoen v. United States Chamber of Commerce*, 30 BRBS 112, 114 (1996); *see also Buchanan v. International Transportation Services*, 31 BRBS 81, 84 (1997). The claimant establishes a *prima facie* case when a licensed physician states that the treatment is necessary for a work-related condition. *Turner v. Chesapeake & Potomac Telephone Co.*, 16 BRBS 255 (1984).

Claimant argues that Employer is liable for all outstanding medical bills of Dr. Nagelberg, Dr. Freed and Dr. Halote, as well as any reasonable and necessary medical treatment for her February 8, 2000, industrial injury, including diagnostic tests and surgery.

With respect to the unpaid medical bills owed to Dr. Nagelberg for services rendered from June 8, 2000,[60] to present, with the exception of the referral made to Dr. Freed at the examination on July 13, 2000, CX 26, p. 47, Employer is not responsible for payment as Claimant's industrial injuries were fully healed by that date, and such treatment was neither reasonable or necessary. Any treatment Claimant received from Dr. Nagelberg following that date was for non-industrial injuries, and is not compensable under the Act. Likewise, the bills for Claimant's right knee surgery are not the responsibility of Employer.

In its pre-trial statement, Employer contends that the medical services rendered by Dr. Halote and Dr. Freed, and the diagnostic studies ordered by Dr. Nagelberg were self-procured within the meaning of section 7(d)(1) of the Act, and are therefore not the responsibility of Employer. ALJX-2, p.3. Regarding the treatment by Dr. Halote, and any diagnostic studies ordered by Dr. Nagelberg after June 8, 2000, the undersigned need not address the issue, as I have already found those injuries treated by those two physicians to be non-industrial in nature.

[60]the date following the last bill of Dr. Nagelberg's that was paid by Employer.

With respect to Dr. Freed's unpaid medical bills, Employer is responsible for payment. Claimant suffered from a neck injury in the accident at issue. Mr. Courtois testified that he had accepted Dr. Nagelberg as Claimant's self-procured physician. Tr. 617. Employer did not dispute Claimant's right to choose to treat with Dr. Nagelberg, and cannot now claim that her choice was unauthorized. It follows, then, that Dr. Freed was not an unauthorized self-procured physician. When a claimant's treating physician makes a referral to a specialist, the employer's consent is not required. *Armfield v. Shell Offshore, Inc.*, 25 BRBS 303 (1992). Dr. Nagelberg referred Claimant to Dr. Freed, an ear, nose and throat specialist. The referral to Dr. Freed was to examine Claimant's ear injury, including her complaints of dizziness, ringing in her ears, and headaches. Employer has conceded that Claimant suffered an injury to her head in the industrial accident. ALJX-2, p.2.[61] Dr. Freed rendered services to Claimant regarding an industrial injury, at the behest of Claimant's treating physician. Dr. Freed is therefore entitled to payment for the services he rendered. As well, Dr. Nagelberg is entitled to payment for the referral to Dr. Freed made on July 13, 2000. CX-26, p. 47

In addition, Employer is liable for any interest which has accrued from the date payment was due until the date of actual payment. See *Hunt v. Director, OWCP,* 999 F.2d 419, 27 BRBS 84(CRT) (9th Cir. 1993), *rev'g Bjazevich v. Marine Terminals Corp.*, 25 BRBS 240 (1991)(interest may be assessed against an employer on overdue medical expenses, whether reimbursement is owed to the provider or to the employee).

Based on the foregoing, the undersigned finds that Employer is responsible for the outstanding medical bills reasonably associated with the services rendered by Dr. Freed on September 25, 2000, and Dr. Nagelberg on July 13, 2000, plus interest at the rate specified in the applicable regulations. The Court further finds that Employer is not responsible for the bills for services rendered after June 8, 2000, (with the exception of the July 13, 2000 visit to Dr. Nagelberg) by Dr. Nagelberg or Dr. Halote, as the evidence shows Claimant's injuries remaining after that date were not on a industrial basis.

Conclusion

Claimant has not sustained her burden in proving the injuries to her right knee, cervical spine and low back are of an industrial nature.

Claimant has failed to established that her psychological condition of a mood disorder related to her orthopedic condition is of an industrial nature. She has similarly failed to establish that she suffers from post-traumatic stress disorder or major depression.

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[61] Employer further relied upon the medical opinion of Dr. Freed in its pre-trial statement, in support of its contention that Claimant was not entitled to further benefits for her injuries. ALJX-2, p.2. Dr. Freed found Claimant's head injury to have reached maximum medical improvement as of September 25, 2000, and found her able to return to work without restriction. EX-14, p.144-147.

Claimant was no longer temporarily totally disabled, and able to return to her full-time longshore position as of March 25, 2000.

Accordingly, the Court finds that Employer has accepted responsibility for Claimant's medical treatment with Dr. Nagelberg up to June 7, 2000. Employer is not responsible for payment of the medical bills of Dr. Nagelberg after June 7, 2000, with the exception of the July 13, 2000 bill. Further, Employer is not responsible for the medical bills of Dr. Halote. Employer is responsible for the medical bills of Dr. Freed.

ORDER

Based upon the foregoing Findings of Fact, Conclusions of Law, and upon the entire record, the Court issues the following Order:

1. Claimant shall receive no benefits for injuries to her right knee, cervical spine, low back and psyche.

2. Claimant shall be entitled to temporary total disability payments for the period of February 9, 2000, through March 24, 2000, in the amount of $901.28 per week.

3. Claimant shall take no monetary compensation thereafter.

4. Employer shall receive a credit for all compensation paid to Claimant from February 9, 2000 to June 7, 2000 ($15,450.64), and from February 15, 2001 through the close of trial, on or about July 27, 2001.

5. Employer is not responsible for Dr. Steven Nagelberg's medical bills after June 7, 2000, with the exception of his July 13, 2000 bill, nor for any medical tests or services he ordered thereafter, except for that rendered by Dr. Freed.

6. Employer is not responsible for Dr. Halote's bills, nor for any services to which Dr. Halote referred Claimant.

7. Employer is not responsible for any bills for psychiatric hospitalization.

8. Employer shall pay Dr. Eugene Freed all monies owed for medical services rendered to Claimant on September 25, 2000.

9. Employer shall pay Dr. Steven Nagelberg all monies owed for medical services rendered to Claimant on July 13, 2000.

10. Employer shall further pay interest on monies owed to Dr. Freed and Dr. Nagelberg at the rate specified in 28 U.S.C. § 1961, computed from the date that each bill was

due until the date of actual payment.

11. The District Director shall make all calculations necessary to carry out this Order.

12. Employer shall provide Claimant all medical care that may in the future be reasonable and necessary for the treatment of the sequelae of the compensable injuries.

13. Counsel for Claimant is hereby ordered to prepare an Initial Petition for Fees and Costs and directed to serve such petition on the undersigned and on counsel for Employer within 21 days of the date this Decision and Order is served. Counsel for Employer shall provide the undersigned and Claimant's counsel with a Statement of Objections to the Initial Petition for Fees and Costs within 21 days of the date the Petition for Fees is served. Within ten calendar days after service of the Statement of Objections, counsel for Claimant shall initiate a verbal discussion with counsel for Employer in an effort to amicably resolve as many of Employer's objections as possible. If the two counsel thereby resolve all of their disputes, they shall promptly file a written notification of such agreement. If the parties fail to amicably resolve all of their disputes within 21 days after service of Employer's Statement of Objections, Claimant's counsel shall prepare a Final Application for Fees and Costs which shall summarize any compromises reached during discussion with counsel for Employer, list those matters on which the parties failed to reach agreement, and specifically set forth the final amounts requested as fees and costs. Such Final Application must be served on the undersigned and on counsel for Employer no later than 30 days after service of Employer's Statement of Objections. Within 14 days after service of the Final Application, Employer shall file a Statement of Final Objections and serve a copy on counsel for Claimant. No further pleadings will be accepted, unless specifically authorized in advance. For purposes of this paragraph, a document will be considered to have been served on the date it was mailed. Any failure to object will be deemed a waiver and acquiescence.

IT IS SO ORDERED.

Anne Beytin Torkington
Administrative Law Judge

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